Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

Initial Health History

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month | Day | Year

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

SURGICAL HISTORY

Please indicate if YOU have a history of any of the following surgeries. Mark all that apply.

- Aneurysm repair
- Aortic aneurysm
- Appendectomy
- Bariatric surgery
- Breast surgery
- Carotid surgery
- CABG (cardiac bypass)
- Cataract surgery
- Colon surgery
- Defibrillator implant
- Gallbladder surgery
- Heart angioplasty / stent
- Heart valve surgery
- Hernia repair
- Hysterectomy
- Orthopedic surgery
- Ovaries removed
- Pacemaker implant
- Plastic surgery
- Prostate surgery
- Stomach surgery
- Thyroid surgery
- Vascular surgery

PATIENT STATUS

- living alone
- living with family / friends
- living with spouse / significant other
- living in an assisted living facility

FAMILY MEDICAL HISTORY

Please indicate which family member(s) have had these illnesses.

FAMILY HISTORY UNKNOWN

	Father	Mother	Brother	Sister	Son	Daughter
Abnormal heart rhythm						
Congenital heart disease						
Diabetes						
Heart disease						
Stroke						
Sudden death						
Valve disease						
None of the above illnesses						

TOBACCO USE

How would you describe your cigarette smoking? never / previous / current (some days) / current (every day)

If you are a FORMER smoker, when did you quit? within the last month / more than 1 year ago

How many packs per day do you (or did you) smoke? never / less than 1 / 1-2 / 2-3 / 3-4

Smoking cessation: not applicable / not yet ready to quit / want to quit now / need help / do not want to quit

Are you exposed to passive (second hand) smoke? yes / no

ALCOHOL USE

How often do you consume alcohol? never / rarely / sometimes / frequently

Number of drinks: 1-2 / 3-4 / 5-6 / 7+

Frequency: monthly / weekly / daily

DRUG USE

none / previously / currently / prefer to discuss with physician

OTHER

Type(s) of caffeine: none / coffee / tea / soft drinks

Number of caffeine drinks per day: occasionally / 1-2 / 3-4 / 5-6 / 7+ / none

Type(s) of exercise: bicycling / walking / running / swimming / aerobics / other

Number of times you exercise per week: occasionally / 1-2 / 3-4 / 5-6 / 7+ / none

Occupation:

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SAMPLE

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