Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions.

Direction of Feed

Personal / Family History

Please answer every question

*Handwritten items must be entered **MANUALLY**. Do not fold this form.*

Marking Instructions

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

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH (Month / Day / Year)

PAST MEDICAL HISTORY

Please indicate if YOU have a history of the following:

- ◯ **NONE**
- ◯ Anemia
- ◯ Asthma
- ◯ Atrial Fibrillation
- ◯ Anxiety Disorder
- ◯ Arthritis
- ◯ Blood Clots
- ◯ Bleeding Disorder
- ◯ Breast Cancer
- ◯ Cervical Cancer
- ◯ Cirrhosis
- ◯ Colon Cancer
- ◯ COPD/Emphysema
- ◯ Depression
- ◯ Diabetes
- ◯ GI Disorders
- ◯ Gastric Reflux (GERD)
- ◯ Gout
- ◯ Cardiac
- ◯ High Blood Pressure
- ◯ HIV (AIDS)
- ◯ Irritable Bowel Syndrome (IBS)
- ◯ Kidney Disease
- ◯ Liver Disease
- ◯ Lung Cancer
- ◯ Collapsed Lung
- ◯ Lupus
- ◯ Melanoma
- ◯ Pulmonary Fibrosis
- ◯ Pulmonary Hypertension
- ◯ Prostate Cancer
- ◯ Rheumatoid Arthritis
- ◯ Seizures
- ◯ Sleep Apnea
- ◯ Skin Cancer (NOT Melanoma)
- ◯ Stroke / TIA (mini-stroke)
- ◯ Stomach Ulcers
- ◯ Thyroid
- **OTHER** (please specify): _____

SURGICAL HISTORY

Please indicate if YOU have had any of the following surgeries:

- ◯ **NO SURGERIES**
- ◯ Aneurysm Repair
- ◯ Appendectomy
- ◯ Back
- ◯ Bladder
- ◯ Breast
- ◯ Cardiac
- ◯ Cataracts
- ◯ Colon
- ◯ Gallbladder
- ◯ Hernia (type): _____
- ◯ Hysterectomy
- ◯ Lung
- ◯ Ovary Removal
- ◯ Pacemaker Placement / Defibrillator
- ◯ Prostate
- ◯ Sinus
- ◯ Stomach
- ◯ Vascular Surgery or Stent
- ◯ Weight Loss Surgery
- **OTHER** (please specify): _____

HABITS

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

Mark any other tobacco products (if used):
◯ cigars ◯ snuff ◯ dip / chewing tobacco ◯ electronic cigarettes
OTHER (please specify): _____

How often do you drink alcohol?
◯ never ◯ rarely ◯ on weekends ◯ a few days a week ◯ daily

Recreational drug use:
◯ none ◯ previous ◯ current ◯ prefer to discuss with physician

FAMILY MEDICAL HISTORY

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

Mother	Father	Sister	Brother	Daughter	Son	
◯	◯	◯	◯	◯	◯	Asthma
◯	◯	◯	◯	◯	◯	Blood Clot in Lung or Leg
◯	◯	◯	◯	◯	◯	Cancer (please specify): _____
◯	◯	◯	◯	◯	◯	Cardiac Disease (Heart Attack / Stent / Bypass)
◯	◯	◯	◯	◯	◯	Congestive Heart Failure
◯	◯	◯	◯	◯	◯	COPD / Emphysema
◯	◯	◯	◯	◯	◯	Diabetes
◯	◯	◯	◯	◯	◯	High Blood Pressure
◯	◯	◯	◯	◯	◯	Renal Disease
◯	◯	◯	◯	◯	◯	Lupus
◯	◯	◯	◯	◯	◯	Sleep Apnea
◯	◯	◯	◯	◯	◯	Pulmonary Fibrosis
◯	◯	◯	◯	◯	◯	Pulmonary Artery Hypertension
◯	◯	◯	◯	◯	◯	Tuberculosis (TB)
◯	◯	◯	◯	◯	◯	Stroke

- ◯ **Family History Unknown**
- ◯ **ADOPTED**
- ◯ **NONE**

OTHER
(please specify condition and relative):
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Employment status:
◯ retired ◯ homemaker ◯ never employed ◯ employed part time
◯ student ◯ disabled ◯ unemployed ◯ employed full time

Education:
◯ high school / GED ◯ some college ◯ masters degree / professional degree
◯ trade school ◯ college degree

Marital status:
◯ single ◯ married ◯ divorced
◯ living with significant other ◯ separated ◯ widowed

*For technical support, please contact PatientLink at **Support@MyPatientLink.com.***