Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Personal / Family History

Please answer every question.

STAFF: Handwritten responses must be entered **MANUALLY**.

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...

Tobacco Use *(for ages 13 and older only)*

How would you describe your cigarette smoking?
current every day ○ former smoker ○
current some days ○ never smoked ○

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

Have you tried quitting / been counseled to quit smoking? yes ○ no ○

please fold on dotted line

Readiness to quit:
not interested in quitting ○
thinking about quitting at some point ○
ready to quit ○

Alcohol Use

How often do you use alcohol?
never ○ 1 – 2 times ○ day ○
social drinker ○ 3 – 4 times ○ per week ○
prefer to discuss with physician ○ 5 – 6 times ○ month ○
7+ times ○

Habits

Do you use recreational drugs?
none ○ previous ○
current ○ prefer to discuss with physician ○

Exercise

Amount:
occasionally ○ 3 – 4 times per week ○
none ○ 5 – 6 times per week ○
1 – 2 times per week ○ 7+ times per week ○

please fold on dotted line

Type:
bicycling ○ aerobics ○
walking ○ swimming ○
running ○ weight training ○
other (please specify): ○

_____

Caffeine intake

Type: coffee ○ tea ○ soft drinks ○

Drinks per day:
occasionally ○ 1 – 2 ○ 5 – 6 ○
none ○ 3 – 4 ○ 7+ ○

How often do you wear a seatbelt?
always ○ occasionally ○
almost always ○ never ○

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Personal / Family History

Please answer every question.

STAFF: Handwritten responses must be entered **MANUALLY**.

YOUR Medical History

Please indicate if **YOU** have a history of the following:

- ◯ Alcohol Abuse
- ◯ Anemia
- ◯ Anesthetic Complication
- ◯ Anxiety Disorder
- ◯ Arthritis
- ◯ Asthma
- ◯ Autoimmune Problems
- ◯ Birth Defects
- ◯ Bladder Problems
- ◯ Bleeding Disease
- ◯ Blood Clots
- ◯ Blood Transfusion(s)
- ◯ Bowel Disease
- ◯ Breast Cancer
- ◯ Cervical Cancer
- ◯ Colon Cancer
- ◯ Depression
- ◯ Diabetes
- ◯ Growth / Development Disorder
- ◯ Heart Attack
- ◯ Heart Disease
- ◯ Heart Pain / Angina
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ HIV
- ◯ Hives
- ◯ Kidney Disease
- ◯ Liver Cancer
- ◯ Liver Disease
- ◯ Lung / Respiratory Disease
- ◯ Lung Cancer
- ◯ Mental Illness
- ◯ Migraines
- ◯ Osteoporosis
- ◯ Prostate Cancer
- ◯ Rectal Cancer
- ◯ Reflux / GERD
- ◯ Seizures / Convulsions
- ◯ Severe Allergy
- ◯ Sexually Transmitted Disease
- ◯ Skin Cancer
- ◯ Stroke / CVA of the Brain
- ◯ Suicide Attempt
- ◯ Thyroid Problems
- ◯ Ulcer
- ◯ Other Disease, Cancer, or Significant Medical Illness
- ◯ **NONE of the Above**

please fold on dotted line

FAMILY Medical History

Please indicate if **YOUR FAMILY** has a history of the following:
(**ONLY** include parents, grandparents, siblings and children.)

- ◯ **Family History Unknown**
- ◯ Alcohol Abuse
- ◯ Anemia
- ◯ Anesthetic Complication
- ◯ Arthritis
- ◯ Asthma
- ◯ Bladder Problems
- ◯ Bleeding Disease
- ◯ Breast Cancer
- ◯ Colon Cancer
- ◯ Depression
- ◯ Diabetes
- ◯ Heart Disease
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ Kidney Disease
- ◯ Lung / Respiratory Disease
- ◯ Migraines
- ◯ Osteoporosis
- ◯ Rectal Cancer
- ◯ Seizures / Convulsions
- ◯ Severe Allergy
- ◯ Stroke / CVA of the Brain
- ◯ Thyroid Problems
- ◯ Other Cancer
- ◯ **NONE of the Above**

please fold on dotted line

- ◯ **Mother**, **Grandmother**, or **Sister** developed heart disease before the age of **65**
- ◯ **Father**, **Grandfather**, or **Brother** developed heart disease before the age of **55**