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

Direction of Feed

Personal / Family History

Please answer every question

To reproduce, follow the printing instructions. 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

Tobacco Use

What is your smoking status? current (every day) ○ current (some days) ○ previous ○ never ○

At what age did you begin smoking?

If you quit smoking, at what age did you quit?

How many cigarettes do you currently smoke or did you previously smoke per day?

EXAMPLE

If you started smoking at the age of 21, you would fill in the ovals like this:

10 ○ 20 ● 30 ○
1 ● 2 ○ 3 ○

10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

How many cigars or pipes do you smoke per week? 0 ○ <1 ○ 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

How many cans of smokeless / chewing tobacco do you use per week? 0 ○ <1/2 ○ 1/2 ○ 1 ○ 2 ○ 3+ ○

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

Alcohol Use

How often do you use alcohol? (Number of times...) never ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7+ ○

(Per...) week ○ month ○ year ○

(If you marked "never", please skip to Drug Use section)

What type(s) of alcohol do you drink? beer ○ wine ○ liquor ○

How many drinks do you have per occasion? 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

How often do you have more than five drinks per occasion? never ○ rarely ○ occasionally ○ frequently ○

Drug Use

none ○ current ○ previous ○ prefer to discuss with physician ○

HIV High Risk Behavior?

(HIV Risk Factors: IV drug use, More than one sexual partner, Sex with a prostitute, Unprotected sexual contact, Contact with contaminated injection equipment.)

yes ○ no ○ prefer to discuss with physician ○

Habits

Caffeine
-type(s) of caffeine: coffee ○ tea ○ soft drinks ○
-drinks per day: occasionally ○ 0 ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

Exercise
-type(s) of exercise: bicycling ○ running ○ swimming ○ walking ○ aerobics ○ other ○
-times per week: occasionally ○ 0 ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

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

Sun Exposure: occasionally ○ frequently ○ rarely ○

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

Direction of Feed

Personal / Family History

Please answer every question

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

YOUR Medical History

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

- ◯ Abdominal Aortic Aneurysm
- ◯ Alcohol Abuse
- ◯ Anemia
- ◯ Anesthetic Complication
- ◯ Anxiety Disorder
- ◯ Arthritis
- ◯ Asthma
- ◯ Bladder Problems
- ◯ Bleeding Disease
- ◯ Blood Transfusion(s)
- ◯ Bowel Disease
- ◯ Breast Cancer
- ◯ Cervical Cancer
- ◯ Colon Cancer
- ◯ Deep Vein Thrombosis
- ◯ Depression
- ◯ Diabetes
- ◯ Heart Attack
- ◯ Heart Disease
- ◯ Heart Pain / Angina
- ◯ Hepatitis
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ HIV
- ◯ Kidney Disease
- ◯ Liver Cancer
- ◯ Liver Disease
- ◯ Lung / Respiratory Disease
- ◯ Lung Cancer
- ◯ Mental Illness
- ◯ Migraines
- ◯ Peripheral Artery Disease
- ◯ Prostate Cancer
- ◯ Pulmonary Embolism
- ◯ Rectal Cancer
- ◯ Reflux / GERD
- ◯ Seizures / Convulsions
- ◯ Skin Cancer
- ◯ Stroke / CVA of the Brain
- ◯ Thyroid Problems
- ◯ Ulcer
- ◯ Vascular Disease
- ◯ Other Disease, Cancer, or Significant Medical Illness
- ◯ **NONE of the Above**

FAMILY Medical History

Please indicate if **YOUR FAMILY** has a history of the following:

◯ **FAMILY HISTORY UNKNOWN** ◯ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

	Father	Mother	Brother	Sister	Son	Daughter
Abdominal Aortic Aneurysm	◯	◯	◯	◯	◯	◯
Alcohol Abuse	◯	◯	◯	◯	◯	◯
Anesthetic Complication	◯	◯	◯	◯	◯	◯
Asthma	◯	◯	◯	◯	◯	◯
Bleeding Disease	◯	◯	◯	◯	◯	◯
Breast Cancer	◯	◯	◯	◯	◯	◯
Colon Cancer	◯	◯	◯	◯	◯	◯
Osteoporosis	◯	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯	◯	◯
High Cholesterol	◯	◯	◯	◯	◯	◯
Kidney Disease	◯	◯	◯	◯	◯	◯
Lung / Respiratory Disease	◯	◯	◯	◯	◯	◯
Peripheral Vascular Disease	◯	◯	◯	◯	◯	◯
Rectal Cancer	◯	◯	◯	◯	◯	◯
Seizures / Convulsions	◯	◯	◯	◯	◯	◯
Stroke / CVA of the Brain	◯	◯	◯	◯	◯	◯
Thyroid Problems	◯	◯	◯	◯	◯	◯
Other Cancer	◯	◯	◯	◯	◯	◯

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