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

Marking Instructions

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

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

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

How would you describe your cigarette smoking?

- current every day
- current some days
- former smoker
- never smoked
- current status unknown

Are you exposed to passive (second hand) smoke?

- current
- former
- never

Have you tried quitting / been counseled to quit smoking?

- yes
- no

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
- social drinker
- prefer to discuss with physician

- 1 – 2 times
- 3 – 4 times
- 5 – 6 times
- 7+ times

per

- day
- week
- month

Habits

Do you use recreational drugs?

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

Exercise

Amount:

- occasionally
- none
- 1 – 2 times per week
- 3 – 4 times per week
- 5 – 6 times per week
- 7+ times per week

Type:

- bicycling
- walking
- running
- aerobics
- swimming
- weight training
- other (please specify): ____________

Caffeine intake

Type:

- coffee
- tea
- soft drinks

Drinks per day:

- occasionally
- none
- 1 – 2
- 3 – 4
- 5 – 6
- 7+

How often do you wear a seatbelt?

- always
- almost always
- occasionally
- never

Copyright © PatientLink Card 273 (Rev. 7/18/2012)
SAMPLE

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**.

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**

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**

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

Copyright © PatientLink Card 273 (Rev. 7/18/2012)
SAMPLE