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

Personal / Family History

Please answer every question

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

How would you describe your cigarette smoking? — 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

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 ○ occasionally ○ rarely ○ frequently ○

Drug Use

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

Exposure History

Have you been exposed to any of the following? Please mark all that apply. If none, mark "**NONE**"

birds ○ textile work ○ fumes ○
sandblasting ○ welding ○ TB (Tuberculosis) ○
asbestos ○ dust ○ **NONE** ○

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+ ○

Personal / Family History

YOUR Medical History

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

- Alcohol Abuse
- Anemia
- Anesthetic Complication
- Anxiety Disorder
- Arthritis
- Asthma
- Attention Deficit Disorder
- Bladder Problems
- Bleeding Disorder
- Blood Clots
- Blood Transfusion(s)
- Breast Cancer
- Bronchiectasis
- Cervical Cancer
- Colon Cancer
- COPD
- Depression
- Diabetes
- Emphysema
- Fibromyalgia
- Heart Attack
- Heart Disease
- Heart Pain / Angina
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- High Cholesterol
- HIV
- Hives
- Hyperthyroidism
- Hypothyroidism
- Insomnia
- Irritable Bowel Disease
- Kidney Disease
- Liver Disease
- Lung / Respiratory Disease
- Lung Cancer
- Migraines
- Narcolepsy
- Osteoporosis
- Pneumothorax
- Prostate Cancer
- Pulmonary Fibrosis
- Pulmonary Hypertension
- Rectal Cancer
- Reflux / GERD
- Sarcoidosis
- Seizures / Convulsions
- Severe Allergy
- Sleep Apnea
- Skin Cancer
- Stomach Ulcer
- Stroke / CVA of the Brain
- Suicide Attempt
- Thyroid Problems

- Other Disease, Cancer, or Significant Medical Illness

- NONE of the Above

FAMILY Medical History

Please indicate if **YOUR FAMILY** have 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
- Blood Clots
- Breast Cancer
- Bronchiectasis
- CHF
- Colon Cancer
- Diabetes
- Depression
- Emphysema
- Fibromyalgia
- Heart Attack
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Insomnia
- Kidney Disease
- Lung Cancer
- Lung / Respiratory Disease
- Migraines
- Narcolepsy
- Osteoporosis
- Pneumothorax
- Pulmonary Fibrosis
- Pulmonary Hypertension
- Rectal Cancer
- Restless Leg Syndrome
- Sarcoidosis
- Seizures / Convulsions
- Severe Allergy
- Sleep Apnea
- Stroke / CVA of the Brain
- Thyroid Problems
- Other Cancer

- NONE of the Above