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 ○

(If you marked "never", please skip to ALCOHOL USE section)

At what age did you begin smoking?

EXAMPLE
If you started smoking at the age of 21, you would fill in the ovals like this:
10 20 30
1 2 3

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

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

(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 drink alcohol?
(Number of times...) never ○ | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ | 6 ○ | 7+ ○
(Per...) week ○ | month ○ | year ○

(If you marked "never", please skip to HABITS 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 ○

HABITS

Caffeine
-type(s) of caffeine: coffee ○ | tea ○ | soft drinks ○
-drinks per day: occasionally ○ | 0 ○ | 1-2 ○ | 3-5 ○ | 6-9 ○ | 10+ ○

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

OTHER

Fall Risk Factors
In the past 12 months:
- Have you fallen? yes ○ no ○
- Have you had difficulty with balance? yes ○ no ○

Abuse & Neglect: In the past year do you feel you have been abused or neglected? yes ○ no ○

Suicide Risk: Do you have thoughts of harming yourself or others? yes ○ no ○

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Personal / Family History

Please answer every question.

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