

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?

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
1 2 3

10	20	30	40	50	60	70	80	90
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1	2	3	4	5	6	7	8	9

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

10	20	30	40	50	60	70	80	90
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1	2	3	4	5	6	7	8	9

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

10	20	30	40	50	60	70	80	90
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1	2	3	4	5	6	7	8	9

How many cigars or pipes do you smoke per week? none 3-5 <1 6-9 1-2 10+

How many cans of smokeless / chewing tobacco do you use per week? none 1 <1/2 2 1/2 3+

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

ALCOHOL USE

Number of times: never 1 2 3

How often do you drink alcohol? Per: 4 5 week month year

(If you marked "never", please skip ahead 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

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 prefer to discuss with physician no

HABITS

Caffeine Type(s) of caffeine: coffee tea soft drinks occasionally none 1-2 3-4 5-6 7+

Exercise Type(s) of exercise: bicycling running swimming walking aerobics other Times per week: occasionally none 1-2 3-4 5-6 7+

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

Sun Exposure: occasionally frequently rarely

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PAST MEDICAL HISTORY

Please indicate if YOU have a history of the following:

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

FAMILY MEDICAL HISTORY

Family History UNKNOWN

NO SIGNIFICANT FAMILY MEDICAL HISTORY

Mother, Grandmother, or Sister developed heart disease before the age of 65

Father, Grandfather, or Brother developed heart disease before the age of 55

Please indicate which family members have had these illnesses:

	Father	Mother	Brother	Sister	Son	Daughter
Alcohol Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anesthetic Complication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bladder Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colon Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lung / Respiratory Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rectal Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures / Convulsions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Severe Allergy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke / CVA of the Brain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things
- Feeling down, depressed, or hopeless

Not at all	Several days	More than half the days	Nearly every day
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>