FAMILY HISTORY

YES	NO	DISEASE	RELATION TO YOU	YES	NO	DISEASE	RELATION TO YOU
_____	_____	Heart Attack	_____	_____	_____	Bleeding Problems	_____
_____	_____	High Blood Pressure	_____	_____	_____	Sickle Cell Anemia	_____
_____	_____	High Cholesterol	_____	_____	_____	Diabetes, High Blood Sugar	_____
_____	_____	Asthma	_____	_____	_____	Thyroid Problems	_____
_____	_____	Tuberculosis	_____	_____	_____	Cancer, Type:	_____
_____	_____	Liver Disease	_____	_____	_____	Cancer, Type:	_____
_____	_____	Kidney Disease	_____	_____	_____	Alcohol Abuse	_____
_____	_____	Gout / Arthritis	_____	_____	_____	Anxiety / Depression	_____
_____	_____	Osteoporosis	_____	_____	_____	Glaucoma	_____
_____	_____	Stroke	_____	_____	_____	Other:	_____
_____	_____	Epilepsy Seizures	_____	_____	_____	Other:	_____

OTHER HISTORY

Exercise: Never _____ Rarely _____ Other: _____

When was your last: Tetanus: _____ (Never) ___ / Hepatitis B: _____ (Never) ___
Pneumovax: _____ (Never) ___ / Flu Shot: _____ (Never) ___

Smoking:
Have you ever smoked? ____ Yes ___ No How many did you smoke per day? ___When did you quit? ____
How many packs per day do you smoke now? _____ Do you use smokeless tobacco: ____ Yes ____ No

The following questions are very important and strictly confidential. Please answer them accurately.

Alcohol / Drugs:
Do you drink alcohol? _____ No _____ Yes How many per day? _____ How often? _____
Do you use drugs? _____ No _____ Yes How much? _____ How often? _____ What kind? _____
What drugs have you used in the past? _____

FEMALE PATIENTS ONLY

of Pregnancies ____ # of Deliveries ____ # of Elective Abortions _____ # of Miscarriages ____

When was your last menstruation? _____ How old were you when you went through menopause? ____

When was your last PAP spear? _____ Have you ever had an abnormal PAP smear? ____Yes ___No

What was the abnormality?

What kind of treatment did you have?

When was your last Mammogram? _____ Have you ever had an abnormal Mammogram? __Yes __No
If "Yes", when was the abnormal Mammogram? _____

The above information is current and correct to the best of my knowledge. I have reviewed this history.

_____	_____	_____	_____
Patient/Guardian Signature	Date	Physician's/PAC's Initials	Date