

FAMILY HISTORY

Have any of your blood relatives had any of the following?

WHO?

WHO?

High Blood Pressure: _____

Diabetes: _____

Heart Attack (include age of 1st attack): _____

Thyroid Disease: _____

Glaucoma: _____

Stroke: _____

Emotional/Nervous problems: _____

Cancer: _____

Other serious illnesses in the family: _____

PAST MEDICAL HISTORY

Hospitalizations or Surgeries (please include psychiatric)

DATE OR AGE

REASON

Serious Injuries: _____

HABITS AND SOCIAL HISTORY

Many of these questions are personal-discuss any you hesitate to answer with your healthcare provider

1) Do you smoke? YES NO
If no, did you ever smoke regularly and quit? YES NO Year Quit: _____

If yes, how many pack of cigarettes a day do you smoke? _____

When did you start smoking? _____

2) Do you drink beer, wine, or liquor? YES NO
If yes, how many per week? _____

3) Do you/ have you ever had problems with drug abuse? YES NO

4) How many times a week do you exercise? _____

5) Do you consider yourself overweight? YES NO

6) Do you wish to receive dietary information to lose weight or lower your cholesterol? YES NO

7) Do you work regularly out in the sun? YES NO