



Name: _____ Date of Birth: _____

Past Medical History

- | | | |
|---|------------------------------|-----------------------------|
| Do you have diabetes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have high blood pressure (hypertension)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have coronary artery disease (CAD)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had a heart attack before? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had any heart procedure (bypass, stent)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had a stroke before? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes, please list what type and when:

Please list your other medical conditions, problems and diagnoses:

None

Please list all surgeries you've had:

None

Please list all your medication allergies:

None

Females: Do you see a gynecologist, if so, whom? No Yes: _____

Number of pregnancies? _____ None How many children? _____ None

Any miscarriages? _____ None Any termination? _____ None

Any ectopic pregnancies? _____ None

Name: _____

Family History

I am adopted. The family history below is what I know about my biological relatives:

Mother: alive died at _____ (age) cause of death: _____

Father: alive died at _____ (age) cause of death: _____

Brother(s): none living (how many) _____ died (how many) _____

Sister(s): none living (how many) _____ died (how many) _____

Family members with breast cancer? none whom: _____

Family members with ovarian cancer? none whom: _____

Family members with prostate cancer? none whom: _____

Family members with colon cancer? none whom: _____

Family members with high blood pressure? none whom: _____

Family members with heart disease? none whom: _____

Family members with diabetes? none whom: _____

Social History

Marital status: married single divorced widowed

Children: none how many _____

Current occupation: retired other: _____

Alcohol use: on an average week, how many alcoholic beverages do you consume?

none _____ (Number of drinks per week)

IV or other drug use? none what: _____

Do you smoke cigarettes? No
 Yes: pack(s) per day _____ some days/not daily

Did you used to smoke? No Yes
If yes: When did you quit? _____
How long did you smoke prior to quitting? _____

How many pack(s) per day before quitting? _____

Do you use other tobacco? No
 Yes: daily some days what: _____