Patient Name: Date: / /

Please List and Supply the Dates of:

Operations: ________ ________ ________

Hospitalizations other than for surgery: ________ ________ ________

Immunization history-have you had:
Hepatitis B? ☐ No ☐ Yes When? ______
Other? ____ ☐ No ☐ Yes When? ______

Pneumovax immunization? ☐ No ☐ Yes When? ______
Flu immunization? ☐ No ☐ Yes When? ______
Tetanus immunization? ☐ No ☐ Yes When? ______

When was your last:
Pap smear? ________ Breast exam? ________ Stool check for blood? ________
Mammogram? ________ Cholesterol check? ________ Prostate exam? ________

Family History

Has any member of our family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Approx. Age When diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other: ________		

Medications (Prescription, Over-the-Counter; Vitamins, Herbs, etc.)

Drug name	Dose	Drug name	Dose:

Prevention

Do you wear seatbelts? ☐ No ☐ Yes If no, why not? ________
Do you wear a bike helmet? ☐ No ☐ Yes ☐ N/A
Do you smoke? ☐ No ☐ Yes If yes, how many packs per day? ________
Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, how much per week? ________
Do you drink coffee? ☐ No ☐ Yes If yes, how many cups per day? ________
Do you drink tea? ☐ No ☐ Yes If yes, how many cups per day? ________
If there is a gun in your home, is it out of children's reach and unloaded? ☐ No ☐ Yes ☐ N/A
Do you use drugs? (Marijuana, cocaine, crack, etc.) ☐ No ☐ Yes If yes, explain: ________
Have you ever engaged in any activity which has put you at risk of getting AIDS? ☐ No ☐ Yes If yes, explain: ________
Do you wish to be tested for AIDS? ☐ No ☐ Yes
Have you ever worked with chemicals, paints, asbestos, or other hazardous material? ☐ No ☐ Yes If yes, explain: ________
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? ☐ No ☐ Yes
Do you ever feel afraid of your partner? ☐ No ☐ Yes

Do you have a "living will"? ☐ No ☐ Yes
Do you have a donor card? ☐ No ☐ Yes
Method of birth control? ________