Patient: ___________________________ Date of Birth _______________ Adult

(Please use pencil to complete this form.)

FAMILY HISTORY

1. Is there any heart disease in your family history? Yes No Unknown
   If yes, circle the problem: High blood pressure, heart attack, high cholesterol, coronary artery bypass, stent placement.
2. Is there any diabetes in your family history? Yes No Unknown
3. Is there any cancer in your family history? Yes No Unknown
   If yes: what type of cancer(s)? ____________________
4. Is there any osteoporosis in your family history? Yes No Unknown
5. Is there any asthma/emphysema in your family history? Yes No Unknown
6. Is there any obesity in your family history? Yes No Unknown
7. Is there any depression in your family history? Yes No Unknown

SOCIAL HISTORY

1. Do you use seat belts? Yes No
2. Do you use ear protection when exposed to loud noises? Yes No
3. Are there any issues with violence or abuse in your life, past or present? Yes No
4. Do you follow good gun safety measures in your household? Yes No N/A
5. Do you use smoke detectors in your house? Yes No
6. Do you use CO detectors? Yes No N/A
7. Do you suffer from depression? Yes No
8. Do you smoke cigarettes or cigars or have you ever smoked? Yes No
   If yes: How many packs per day? _______ How many years?_______________
   Did you quit? Yes No When? _____________
9. Have you ever used illegal drugs? Yes No
10. Have you ever practiced high risk sexual behaviors? Yes No
    If yes, do you feel you need testing for sexually transmitted diseases? Yes No
11. Do you exercise? Yes No _______________________If yes, how often?_____________________
12. Do you follow a good diet with lots of fruits and vegetables and limited fat? Yes No
13. Do you currently have a weight problem? Yes No
14. Do you participate in any unique activities/challenges that are hazardous to your health? Yes No
    If yes, what? _____________________________
15. What is your current marital status? _______________________
16. Do you use alcohol? Yes No
    If yes, how much do you drink? _____________________________
    If yes, please answer the following questions:
    1. Have you ever felt you should cut down on your drinking? Yes No
    2. Have people annoyed you by criticizing your drinking? Yes No
    3. Have you ever felt bad or guilty about your drinking? Yes No
    4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes No

Patient:______________________________ Date of Birth: ________________Adult

17. Do you have a power of attorney? Yes No
18. Do you have a living will? Yes No
19. Have you had an eye exam within the past two years? Yes No
20. Have you had a dental exam in the past year? Yes No
21. Have you had your hearing tested in the last two years? Yes No

IMMUNIZATIONS

Date of last TETANUS? ______________-Needed every 10 years
Date of last PNEUMOVAX? ______________
Date of last FLU SHOT? _______________

REVIEW OF SYSTEMS

1. Have you had any problems with your skin or moles that are changing? ____________________
   ____
2. Have you had any bone, joint or muscle aches or pains? __________________________________
   ____
3. Have you had any fatigue, weakness or bleeding disorders? ______________________________
   ____
4. Have you had any vision changes, headaches or dizziness? _______________________________
   ____
5. Have you had any problems involving your ears, nose or throat? __________________________
   ____
6. Have you had any difficulty breathing, wheezing or respiratory problems? __________________
   ____
7. Have you had any chest pain, palpitations, or other heart problems? ______________________
   ____
8. Have you had any problems with your digestive system? _________________________________
   ____
9. Have you had any problems urinating? ____
   ____
10. Are there any other health problems you have been having? ______________________________
   ____

UPDATED: ____________/_____________/_____________/______________/__________
____________/_____________/_____________/______________/_____

This is a worksheet used for obtaining changing information to update the patient's chart. It is not part of the patient's legal record. 10/1/01ds