



**OPERATIONS:**  No  Yes (please list)

Type of Operation	When

**OTHER HOSPITALIZATIONS:**  No  Yes (please list)

Reason	When

**Vaccination History- Have you had?**

Hepatitis B  No  Yes When? \_\_\_\_\_

Other?  No  Yes When? \_\_\_\_\_

When was your last?

Pap Smear \_\_\_\_\_ Breast Exam \_\_\_\_\_

Mammogram \_\_\_\_\_ Cholesterol Check \_\_\_\_\_

**Tetanus Immunization**

No  Yes When? \_\_\_\_\_

**Flu Immunization**

No  Yes When? \_\_\_\_\_

**Pneumonia Immunization**

No  Yes When? \_\_\_\_\_

Stool Check for Blood \_\_\_\_\_

Prostate Exam \_\_\_\_\_

**FAMILY HISTORY: Has any member of your family (incl. parents, grandparents, and siblings) had the following?**

Illness	Which Family Member?	Approximate Age when diagnosed
Cancer (describe type)		
High Blood Pressure		
Heart Disease		
Diabetes		
Stroke		
Mental Illness (anxiety, depression, etc.)		
Blood/clotting Disease		
Other:		

**MEDICATIONS: (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)**

Drug Name	Dose

Drug Name	Dose

**PREVENTION:**

Do you wear seat belts?

No  Yes

If no, why not? \_\_\_\_\_

Do you wear a bicycle or motorcycle helmet?

No  Yes  Not applicable

Do you smoke or use tobacco products?

No  Yes If yes, how many packs/day? \_\_\_\_\_

Do you drink alcoholic beverages?

No  Yes If yes, how much/week? \_\_\_\_\_

Is there a gun in your home?

No  Yes

Do you use drugs? (marijuana, cocaine, crack, etc.)

No  Yes If yes, list \_\_\_\_\_

Any behaviors which would increase your risk of AIDS?

No  Yes If yes, list \_\_\_\_\_

(IV drug use, unprotected intercourse, same sex relationship)

No  Yes

Do you wish to be tested for AIDS?

No  Yes

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?

No  Yes

If Yes, please explain \_\_\_\_\_

Have you ever been afraid in your home?

No  Yes

Do you have a "living will"?

No  Yes

Are you an organ donor?

No  Yes

**FOR PHYSICIAN USE ONLY**

Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_