

Please List and Supply the Dates of:

Operations: _____

Hospitalizations other than for surgery: _____

Immunization history-have you had: Pneumovax immunization? No Yes When? _____

Hepatitis B? No Yes When? _____ Flu immunization? No Yes When? _____

Other? 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? _____

Procedures-have you had: Arthroscopy? No Yes When? _____ Colonoscopy? No Yes When? _____

Upper G.I.? No Yes When? _____ Lower G.I.? No Yes When? _____ CT Scan? No Yes When? _____

MRI's? No Yes When? _____ Chest x-ray? No Yes When? _____ Echocardiogram? No Yes When? _____

Stress test? No Yes When? _____ Other? _____

Family History

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

Illness	Which family members	Which family members
Cancer (describe type) _____	_____	Mental disease (anxiety, depression, etc.) _____
Hypertension _____	_____	Drug or alcohol addiction _____
Heart disease _____	_____	Glaucoma _____
Diabetes _____	_____	Bleeding diseases _____
Other: _____	_____	_____

Prevention

- Do you wear seat belts? Yes No If not, why not? _____
- Do you wear a bike helmet? Yes No N/A
- Do you smoke? Yes No If yes, how many packs per day? _____
- Do you drink alcoholic beverages? Yes No If yes, how much per week? _____
- Do you drink coffee? Yes No If yes, how many cups per day? _____
- Do you drink tea? Yes No If yes, how many cups per day? _____
- If there is a gun in your home, do you keep it unloaded and out of children's reach? Yes No N/A
- Do you use drugs? (marijuana, cocaine, crack, etc.) Yes No If yes, explain: _____
- Have you ever engaged in any activity which has put you at risk of getting AIDS? Yes No If yes, explain: _____
- Do you wish to be tested for AIDS? Yes No
- Have you ever worked with chemicals, paints, asbestos, or other hazardous material? Yes No If yes, explain: _____
- Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Yes No
- Do you ever feel afraid of your partner? Yes No N/A
- Do you have a "living will"? Yes No
- Do you have a donor card? Yes No
- Have you ever visited the dentist? Yes No
- Have you ever had an eye exam? Yes No
- Method of birth control? _____

Physician Signature	Date	Physician Signature	Date
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