

Personal Health History:

Have you ever been treated for any of the following illnesses? If yes, place a check mark in the box next to the illness and enter the approximate date, year.

Illness	<input type="checkbox"/>	Year	Illness	<input type="checkbox"/>	Year
Migraine Headaches	<input type="checkbox"/>		Ulcer	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>		Diverticulosis	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>		Colitis	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>		Yellow Jaundice	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>		Liver Trouble	<input type="checkbox"/>	
Other Eye Problems	<input type="checkbox"/>		Gallbladder Trouble	<input type="checkbox"/>	
Deafness	<input type="checkbox"/>		Hernia	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>		Hemorrhoids	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>		Kidney Disease	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>		Bladder Disease	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>		Prostate Problems	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>		Kidney Stones	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>		Arthritis	<input type="checkbox"/>	
Other Lung Problems	<input type="checkbox"/>		Chicken Pox	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>		Hepatitis	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>		Measles	<input type="checkbox"/>	
Poor Circulation	<input type="checkbox"/>		Psoriasis	<input type="checkbox"/>	
Heart Murmur	<input type="checkbox"/>		Mental Illness	<input type="checkbox"/>	
Bleeding Tendency	<input type="checkbox"/>		Substance Abuse	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>		Alcoholism	<input type="checkbox"/>	
Other Heart Condition	<input type="checkbox"/>		AIDS / HIV	<input type="checkbox"/>	
Breast Cancer	<input type="checkbox"/>		Venereal disease	<input type="checkbox"/>	
Colon Cancer	<input type="checkbox"/>		Thyroid Disease	<input type="checkbox"/>	
Prostate Cancer	<input type="checkbox"/>		Rheumatic Fever	<input type="checkbox"/>	
Other Cancer	<input type="checkbox"/>			<input type="checkbox"/>	

Have you had any serious injury? Yes No

TYPE	DATE

Family Health History

Has any member of your immediate family (mother, father, brother, sister, aunt, uncle, grandparent or child) ever been treated for any of the following illnesses? If yes, place a check mark in the box and enter the relative's relationship to you.

Illness	Check	Relationship to You
Migraine Headaches		
Stroke		
Seizures		
Glaucoma		
Deafness		
Emphysema		
Allergies		
Asthma		
High Blood Pressure		
Heart Attack		
High Cholesterol		
Bleeding Tendency		
Ulcer		
Colitis		
Kidney Disease		
Arthritis		
Diabetes		
Mental Illness		
Substance Abuse		
Thyroid Disease		
Breast Cancer		
Colon Cancer		
Prostate Cancer		
Other Cancer		

Health Maintenance:

Have you ever had a sigmoidoscopy? If so, when? _____

Female Only:

Have you ever had a mammogram? If yes, date of most recent? _____

Do you examine your breasts monthly? Yes No

Date of last PAP smear: _____ Any abnormal PAPs? _____

Lifestyle:

Do you live: Alone with friends with Spouse/children
 with spouse with significant other Relatives

of people in household: _____

What are your hobbies/interests? _____

What is (was, if retired) your occupation? _____

How many hours per week do you spend at your job? _____ Retired

Are you/have you been exposed to hazardous materials? If yes, what kind: _____

How many hours of sleep per day/night do you get? _____

Do you exercise regularly? Yes No If yes, what kind? _____

Do you warm-up before exercising? Yes No

If you ride a bike, do you wear a helmet? Yes No

Do you wear sunblock? Yes No

Do you wear seat-belts? Yes No

Are you on a special diet? Yes No If so, type? _____

Do you smoke? Yes No How much?

Do you drink alcohol? Yes No Drinks per week?

Do you drink caffeine? Yes No Drinks per day?

Do you use any non-prescription drugs? Yes No

Are there any religious issues that may affect your care? Yes No

Do you need assistance with performing daily activities? Yes No

Have you been the victim of sexual, emotional, or physical abuse / neglect? Yes No

Decision Making:

Do you have a living will? Yes No

Do you have a durable power of attorney for health care? Yes No

If you need more information about the above, ask your physician.