

## FAMILY HISTORY

Have any of your blood relatives had any of the following?

WHO?

WHO?

High Blood Pressure: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Heart Attack (include age of 1<sup>st</sup> attack): \_\_\_\_\_

Thyroid Disease: \_\_\_\_\_

\_\_\_\_\_

Glaucoma: \_\_\_\_\_

Stroke: \_\_\_\_\_

Emotional/Nervous problems: \_\_\_\_\_

Cancer: \_\_\_\_\_

\_\_\_\_\_

Other serious illnesses in the family: \_\_\_\_\_

## PAST MEDICAL HISTORY

Hospitalizations or Surgeries (please include psychiatric)

**DATE OR AGE**

**REASON**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Serious Injuries: \_\_\_\_\_

\_\_\_\_\_

## HABITS AND SOCIAL HISTORY

Many of these questions are personal-discuss any you hesitate to answer with your healthcare provider

1) Do you smoke?      YES      NO

If no, did you ever smoke regularly and quit?      YES      NO      Year Quit: \_\_\_\_\_

If yes, how many pack of cigarettes a day do you smoke? \_\_\_\_\_

When did you start smoking? \_\_\_\_\_

2) Do you drink beer, wine, or liquor?      YES      NO

If yes, how many per week? \_\_\_\_\_

3) Do you/ have you ever had problems with drug abuse?      YES      NO

4) How many times a week do you exercise? \_\_\_\_\_

5) Do you consider yourself overweight?      YES      NO

6) Do you wish to receive dietary information to lose weight or lower your cholesterol?      YES      NO

7) Do you work regularly out in the sun?      YES      NO