PATIENT NAME (Last, Middle, First)_____ **Date of Birth** _____

FAMILY HISTORY:

attach additional sheet(s), as needed

ISSUE	**1. List FAMILY MEMBER (S)** (Brother, Daughter, Father, Maternal Aunt, Maternal Grandfather, Maternal Grandmother, Maternal Uncle, Mother, Paternal Aunt, Paternal Grandfather, Paternal Grandmother, Paternal Uncle, Sister, Son, Unspecified Relation) **2. AGE WHEN DIAGNOSED** **3. AGE AT DEATH, IF NO LONGER LIVING**
Alcohol abuse	
Alzheimer's disease	
Anemia	
Anxiety disorder	
Arthritis	
Asthma	
Attention deficit hyperactivity disorder (ADHD)	
BRCA1 mutation (carrier of Gene 1 for breast cancer)	
BRCA2 mutation (carrier of Gene 2 for breast cancer)	
Bipolar disorder	
Blood clotting disorder	
Cerebrovascular accident	
Chronic obstructive lung disease (COPD)	
Coronary arteriosclerosis	
Dementia	
Depression	
Diabetes	
Disease of liver	
Disorder of nervous system	
Disorder of thyroid gland	
Endometrial cancer cancer of the uterus lining)	
Epilepsy	

Headache	
Heart disease	
History of attempted suicide	
Hypercholesterolemia (high cholesterol)	
Hypertensive disorder (high blood pressure)	
Kidney disease	
Liver problem	
Uterine cancer	
Breast cancer	
Cervical cancer	
Colon cancer	
Lung cancer	
Ovarian cancer	
Mental disorder (**other** than Anxiety, Depression, Bipolar, Panic, Personality, Schizophrenia)	
Migraine	
Multiple sclerosis	
Myocardial infarction (heart attack)	
Obesity	
Osteoporosis	
Panic disorder	
Personality disorder	
Schizophrenia	
Seizures (NOT epilepsy)	
Sexual abuse	
Sleep disorder	
Substance abuse	

Social History

Activities of Daily Living

Are you able to care for yourself? Yes No

Are you blind or do you have difficulty seeing? Yes No

Are you deaf or do you have serious difficulty hearing? Yes No

Do you have difficulty concentrating, remembering, or making decisions? Yes No

Do you have difficulty walking or climbing stairs? Yes No

Do you have difficulty dressing or bathing? Yes No

Do you have difficulty doing errands alone? Yes No

Are you able to walk? Yes No

Do you have transportation difficulties? Yes No

Diet and Exercise

What type of diet are you following? Regular Vegetarian Vegan Gluten-Free Specific Carbohydrate Cardiac Diabetic

What is your exercise level? None Occasional Moderate Heavy

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____

What types of sporting/exercise activities do you participate in? _____

Education and Occupation

What is the highest grade or level of school you have completed or the highest degree you have received? _____

Are you currently employed? Yes No

What is your Occupation? _____

Substance Use

Do you or have you ever smoked tobacco? Never Smoked (if never smoked, skip questions below about smoking tobacco)

Former smoker Current every day smoker Current some days smoker

At what age did you start smoking tobacco? _____

How much tobacco do you smoke? _____ packs per day **OR** _____ packs per week

How many years have you smoked tobacco? _____

Do you or have you ever used any other forms of tobacco or nicotine? Yes No

Do you or have you ever used e-cigarettes or vapes? Never Former User Current User

Do you or have you ever used smokeless tobacco? Never Former User Current User

Current Snuff User: Yes No Currently Chews Tobacco: Yes No Currently Uses Moist Powdered Tobacco: Yes No

What is your level of alcohol consumption? None Occasional Moderate Heavy

*If you are pregnant, what was your level of alcohol consumption prior to pregnancy? None Occasional Moderate Heavy

Do you use any illicit or recreational drugs? Yes No *If yes, how many years _____ and which ones:

_____

Do you use marijuana? Yes No

Have you used IV drugs? Yes No

What is your level of caffeine consumption? None Occasional Moderate Heavy

Marriage and Sexuality

What is your relationship status? Unknown Married Single Divorced Separated Widowed Domestic Partner Other

Are you sexually active? Yes No

How many children do you have? _____

Home and Environment

Have there been any changes to your family or social situation? Yes No

What type of child-care do you use? None Relative Private sitter Daycare/ Preschool

Do you have any pets? Yes No

Do you have smoke and carbon monoxide detectors in your home? Yes No

Are you passively exposed to smoke? Yes No

Are there any guns present in your home? Yes No Prefer Not to Answer

What is the fluoride status of your home? Fluoridated Non-Fluoridated Unknown

Do you use insect repellent routinely? Yes No

Do you use sunscreen routinely? Yes No

Lifestyle

Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?
Not at all Only a little To some extent Rather much Very much

General Stress Level High Medium Low

Do you participate in social media? Yes No

Do you wear a helmet when biking? Yes No

Do you use your belt or car seat routinely? Yes No

Public Health and Travel

Have you been to an area known to be high at risk for COVID-19? Yes No

In the 14 days before symptom onset, have you ever had close contact with a laboratory-confirmed COVID-19 while that case was ill? Yes No

In the 14 days before symptom onset, have you had close contact with a person who is under investigation for COVID-19 while that person was ill? Yes No

Have you recently or are you planning to travel to an area with Zika virus? Yes No

Advance Directive

Do you have an advanced directive? Yes No Is a blood transfusion acceptable in an emergency? Yes No

Gender Identity and LGBQT Identity

Gender Identity _____ Assigned Sex at Birth: Male Female Unknown Choose Not to Disclose

Pronouns: he/him she/her they/them First Name Used _____ Sexual Orientation _____

Surgical History (N/A if this does not apply)

Procedure & Date of Procedure

_____ _____

_____ _____

_____ _____

_____ _____

Date of Last Colonoscopy _____

Implant History (N/A if this does not apply)

Type of Implant & Date of Implant

_____ _____

_____ _____

Gynecological History (N/A if this does not apply)

Date of Last Mammogram _____

Date of Last Pap Smear _____ Abnormal Pap: Yes No

First Period, what age? _____

Date of Last Menstrual Period _____

Duration of Flow (how many days) _____

Flow is: Light Moderate Heavy

Frequency of Cycle (how many days is your cycle?) _____

Hormone replacement therapy Yes No

If Post-Menopausal, Age at Menopause _____

Date of Most Recent Bone Density Scan _____

Obstetric History (only answer as applicable or N/A)

Total Number Of Pregnancies: _____

Of Total Pregnancies, how many were:
Full-Term _____
Premature _____
Abortions _____
Spontaneous Abortions/Miscarriages _____
Ectopic _____
Multiple Births _____

How many living children do you have? _____

Past Medical History (circle all that apply and list date of onset)

ADD/ADHD

AIDS/HIV

Abuse/Domestic Violence

Alcohol Abuse

Allergies (Hay fever)

Amnesia

Anemia

Anesthesia Complications

Aneurysm

Angina

Anxiety disorder

Arrhythmia (irregular heartbeat)

Arthritis

Asthma

Atrial Fib (irregular & rapid heartbeat)

Auditory Hallucinations

Back Pain

Birth Defects

Birth Defects of Inherited Disease

Bladder or Kidney Problems

Blood clots

Blood Disorders

Blood Transfusion

Brain Injury

Breast Cancer

Breast Problem

COPD

Cancer

Carpal Tunnel

Chicken Pox

Chronic Ear Infections

Congestive Heart failure

Constipation

Coronary Artery Disease

Crohn's Disease

Depression

Developmental or Behavioral Disorders

Diabetes

Difficulty Swallowing

Diverticulitis/ Diverticulosis

Ear or hearing problems

Eating disorder

Eczema

Endometriosis

Fibromyalgia

GERD/Reflux

GI Problems

Gout

Headaches

Heart Attacks

Heart Disease

Heart Problems

Hepatitis

Hernia

Hernia Hiatal

Hernia Inguinal

Hernia Umbilical

High Cholesterol

Hypertension (high blood pressure)

Hyperthyroidism (overactive thyroid)

Hypothyroidism (underactive thyroid)

Kidney Disease

Kidney Stones

Learning Disorder

Leg or Foot Ulcers

Liver Disease

Lung Disease

Lupus

MRSA

Meniere's Disease (chronic vertigo)

Mental Illness

Muscle, Joint, or Bone Problems

Neck Injury

Neurological Disorder

Neuropathy

Obesity

Osteoarthritis

Osteoporosis

Peripheral Vascular Disease

Pre-Eclampsia

Prostate Problems

Psoriasis

Psychiatric/Mental Health conditions

Pulmonary Embolism

Rheumatoid Arthritis

Schizophrenia

Seizures/Epilepsy

Skin Problems

Sleep Apnea

Stroke

Thrombophilia

Thyroid Disease

Tourette Syndrome

Tuberculosis

Ulcerative Colitis

Vascular Disease

Vision or Eye Problems

Visual Hallucinations

OTHER:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies

List ALL Medication Allergies & Your Reaction Type for each Medication

_____ _____ _____

_____ _____ _____

_____ _____ _____

List ALL Food Allergies & Your Reaction Type for each Food

_____ _____ _____

_____ _____ _____

_____ _____ _____

List OTHER Allergies & Your Reaction Type for each Other

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Medications & Health Issues

Attach a List of Current Medications (any prescriptions or over the counter medications, including vitamins, supplements, etc.) or list **ALL** current medications below:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

What health issues/conditions do you currently have? e.g. Diabetes, Hypertension, Heart Disease

_____ _____ _____

_____ _____ _____

List any recent hospitalizations. Include date(s) and reasons for hospitalization.

_____

_____

Signature: _____ Date: _____