

HOSPITALIZATION & SURGICAL HISTORY -- List all hospital admissions and operations you have had.

<i>Reason for Hospitalization/Surgery</i>	<i>Year</i>
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____
7 _____	_____
8 _____	_____
9 _____	_____
10 _____	_____

YES NO Do you have any problems with anesthesia? If YES, please describe.

SOCIAL HISTORY

YES NO Do you currently smoke or use other tobacco products? If YES,
How many per day? . . . _____

YES NO Have you smoked or used other tobacco products in the past? If YES,
How many per day? . . . _____ How many years since you last smoked? _____

YES NO Do you drink caffeinated beverages? If YES,
What type, how often, how much? _____

YES NO Do you drink alcohol? If YES,
What type, how often, how much? _____

YES NO Do you exercise regularly? If YES,
What type? _____
How often and how long? _____

FAMILY MEDICAL HISTORY -- Check the box next to any medical condition below that has affected any of your immediate family members (parents, brothers, sisters), state your relationship and their age at onset.

	<i>Relationship</i>	<i>Age at onset</i>
High Blood Pressure		
High Cholesterol		
Heart Disease		
Stroke		
Migraines		
Seizures/Convulsions		
Diabetes		
Bleeding/Blood-clotting Disorder		
Allergies		
Asthma		
Thyroid Problems		
Osteoporosis		
Psychiatric Disorder/Mental Illness		
Alzheimer's/Dementia		
Cancer - type:		
Other:		
Other:		

SCREENINGS -- List the most recent date and doctor for the following screenings.

	<i>Date</i>	<i>Doctor/Practice or Facility Name</i>
Complete medical physical	_____	_____
Full panel of lab work	_____	_____
Cholesterol (lipid) screening	_____	_____
Chest X-ray	_____	_____
Treadmill stress test	_____	_____
Other heart tests	_____	_____
Colonoscopy	_____	_____
Mammogram	_____	_____
Bone density	_____	_____