

Past Medical ✓ **History (Tick the Box)**

Atrial Fibrillation	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>
Aortic Stenosis	<input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Nerve/muscle disease	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	Deep vein thrombosis	<input type="checkbox"/>	Neurologic Disease	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	Alcohol Problem	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Pulmonary embolism	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Myocardial infarction	<input type="checkbox"/>	Infection w/ MRSA	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Blood clotting disorder	<input type="checkbox"/>	Infection with VRE	<input type="checkbox"/>	Emphysema (COPD)	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	Obstructive sleep apnea	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	End stage renal disease	<input type="checkbox"/>
Blood vessel blockage	<input type="checkbox"/>	Brain tumor	<input type="checkbox"/>	Urinary insufficiency	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	Obesity	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	Migraine h/a	<input type="checkbox"/>	Drug abuse	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	Sexually transmitted Disease	<input type="checkbox"/>

Other MEDICAL History

Social History

Tobacco Use: Non Smoker Smoker Former Smoker Quit Date _____

How Often Do You Smoke: Daily Some days, but not every day #Of Cigarettes some in a day

Alcohol Use

Question 1: How often did you have a drink containing alcohol in the past year?

Never Monthly or less 2 to 4 times a month 2 to 3 times per week
4 or more times a week

Question 2: How many drinks did you have on a typical day when you were drinking in the past year?

1 or 2 3 or 4 5 or 6 7 to 9 10 or more

Question 3: How often did you have six or more drinks on one occasion in the past year?

Never Less than monthly Monthly Weekly Daily or almost daily

Family History

Check if any first degree relative has any Medical Problem.

Medical Conditions	Father	Mother	Siblings	Other
High Blood Pressure				
High Cholesterol				
Heart Disease				
Diabetes				
Stroke				
Cancer				
Migraines				
Thyroid Issues				
Alcoholism				
Mental Illness				
Others/Specify				