Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Hansen Family Practice, LLC

2300 12th Ave. S. Suite 128

Great Falls, MT. 59405

(406) 866-0280

Adult Medical History Form

Please complete all pages

*Your answers on this form will help your provider understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific detail. Thank you.*

Age: ­­­­\_\_\_\_\_\_\_\_\_\_ How would you rate your general health? □ Excellent □ Good □Fair □Poor

**Reason For Visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is most important to you about your medical care? (e.g. communication, prevention, wellness planning)

**Medications, Vitamins and Herbal Supplements**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medications | Dose | How Often | For How Long | For What Reason |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Which Pharmacy (ies) do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**ALLERGIES:**

Do you have any of the following allergies and if so please list or describe reaction

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Environmental (animals, grasses, pollen etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

When were your most recent **IMMUNIZATIONS**?

Hepatitis A\_\_\_\_\_\_\_ Hepatitis B\_\_\_\_\_\_\_ Influenza (Flu shot) \_\_\_\_\_\_ Measles \_\_\_\_\_\_\_

Pneumovax (pneumonia) \_\_\_\_\_\_ Rubella \_\_\_\_\_\_\_\_ Tetanus (Td) \_\_\_\_\_\_\_

Varicella (chicken pox) \_\_\_\_\_\_\_ Shingles \_\_\_\_\_\_\_\_ Gardasil \_\_\_\_\_\_\_\_

When were your most recent HEALTH MAINTENANCE screening tests?

Lipid (Cholesterol Screening) \_\_\_\_\_\_\_\_\_\_\_ Results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PSA (Prostate cancer screen)\_\_\_\_\_\_\_\_\_\_ Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mammogram\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ever abnormal?\_\_\_\_\_

Stool test for blood? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pap Smear? \_\_\_\_\_\_\_\_\_ Results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ever abnormal?\_\_\_\_\_

Last time you went to a dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you perform monthly:

Self-Breast Exams □ NA □Yes □No

Self-Testicular Exams □NA □Yes □No

Surgical History

­­­­­­­­­1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalization

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

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

**Personal Medical History**

(please check if you have had or have any of these conditions and list when)

□Angina (chest pain)\_\_\_\_\_\_\_

□Abnormal EKG\_\_\_\_\_\_\_

□Anemia\_\_\_\_\_\_\_\_\_

□Arrhythmia (irregular heart beat)\_\_\_\_\_\_\_

□Bleeding Disorder\_\_\_\_\_\_\_\_\_\_\_

□Blood Clots \_\_\_\_\_\_\_\_

□Fainting or lightheadedness \_\_\_\_\_\_\_\_\_

□Heart Attack\_\_\_\_\_\_\_\_\_\_

□Heart Disease \_\_\_\_\_\_\_\_\_\_

□Heart Murmur\_\_\_\_\_\_\_\_\_

□Heart Surgery\_\_\_\_\_\_\_\_\_\_

□High Blood Pressure\_\_\_\_\_\_\_\_\_\_

□Low Blood Pressure\_\_\_\_\_\_\_\_\_\_

□High Cholesterol\_\_\_\_\_\_\_\_\_\_\_

□Pacemaker/Other Cardiac Implants\_\_\_\_\_\_\_\_\_\_\_

□Palpitations\_\_\_\_\_\_\_\_\_\_\_\_\_

□Rheumatic Fever\_\_\_\_\_\_\_\_\_\_\_

□Stroke\_\_\_\_\_\_\_\_\_\_\_\_

□Swelling in ankles/feet\_\_\_\_\_\_\_\_\_\_\_\_

□Varicose Veins\_\_\_\_\_\_\_\_\_\_\_

□TIA (mini stroke)\_\_\_\_\_\_\_\_\_\_\_

□Difficulty Getting or Maintaining an Erection \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Other Cardiac Problems\_\_\_\_\_\_\_\_\_\_\_

□Abnormal Chest Xray\_\_\_\_\_\_\_\_\_\_\_

□Allergies (Environmental)\_\_\_\_\_\_\_\_\_\_

If so, do you have pets/carpet in your home?\_\_\_\_\_

□Asthma \_\_\_\_\_\_\_\_\_\_

□Bronchitis\_\_\_\_\_\_\_\_\_\_\_

□COPD\_\_\_\_\_\_\_\_\_\_\_

□Chronic Cough\_\_\_\_\_\_\_\_\_\_\_

□Cough at Night\_\_\_\_\_\_\_\_\_\_\_

□Emphysema\_\_\_\_\_\_\_\_\_\_

□Influenza\_\_\_\_\_\_\_\_\_\_\_

□Home Oxygen Use\_\_\_\_\_\_

How many liters? \_\_\_\_ (L)

□Lung Disease\_\_\_\_\_\_\_\_\_\_

□Pneumonia\_\_\_\_\_\_\_\_\_\_\_\_

□Pleurisy (lung pain)\_\_\_\_\_\_\_\_\_

□Second Hand Smoke Exposure\_\_\_\_\_\_\_\_\_

□Workplace Respiratory Toxins\_\_\_\_\_\_\_\_\_

□Sleep Apnea

□Shortness of Breath\_\_\_\_\_\_\_\_\_\_

□Snoring\_\_\_\_\_\_\_\_\_\_\_\_

□Tuberculosis\_\_\_\_\_\_\_\_\_\_\_\_\_

□Coughing up Blood\_\_\_\_\_\_\_\_\_

□Other Respiratory Conditions

□Cataracts\_\_\_\_\_\_\_\_\_\_

□Dental Problems\_\_\_\_\_\_\_\_\_\_\_\_

□Epilepsy\_\_\_\_\_\_\_\_\_\_

□Ear Infections (chronic)\_\_\_\_\_\_\_

□Eye/Vision Problems\_\_\_\_\_\_\_\_

□Glaucoma\_\_\_\_\_\_\_\_\_

□Impaired Hearing\_\_\_\_\_\_\_\_\_\_\_\_

□Sinus Problems\_\_\_\_\_\_\_\_\_\_\_\_\_

□Mononucleosis\_\_\_\_\_\_\_\_\_\_\_\_

□Strep Throat\_\_\_\_\_\_\_\_\_\_

□ Shingles\_\_\_\_\_\_\_\_\_\_

□ Tinnitis (ringing in ears)\_\_\_\_\_\_

□ Other Eyes, Ears or Throat Conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Abdominal Pain\_\_\_\_\_\_\_\_\_\_\_\_

□Bloody or Black Stools\_\_\_\_\_\_\_\_

□Bowel Problems \_\_\_\_\_\_\_\_\_\_\_

□Bloody Vomit\_\_\_\_\_\_\_\_\_\_\_\_

□Cirrhosis\_\_\_\_\_\_\_\_\_\_\_\_\_

□Colitis\_\_\_\_\_\_\_\_\_\_\_

□Constipation\_\_\_\_\_\_\_\_\_\_\_

□Diarrhea\_\_\_\_\_\_\_\_\_\_\_

□Digestive Problems\_\_\_\_\_\_\_\_\_

□Diverticulitis\_\_\_\_\_\_\_\_\_\_\_\_

□Heart Burn\_\_\_\_\_\_\_\_\_\_\_

□Feeling Full after Eating a Little\_\_\_\_\_\_

□Gall Bladder Disease\_\_\_\_\_\_\_\_\_

□Hemorrhoids\_\_\_\_\_\_\_\_\_\_\_\_

□Hepatitis\_\_\_\_\_\_\_\_\_\_\_

□Hernia\_\_\_\_\_\_\_\_

□Incontinence of Stool\_\_\_\_\_\_

□Irritable Bowel \_\_\_\_\_\_\_\_\_

□Parasites\_\_\_\_\_\_\_\_

□Persistent Nausea\_\_\_\_\_\_\_\_\_\_\_\_

□Persistent Vomiting\_\_\_\_\_\_\_\_\_

□Swallowing Problems\_\_\_\_\_\_\_\_

□Ulcer\_\_\_\_\_\_\_\_\_\_

□Other Abdominal Problems\_\_\_\_\_\_\_\_\_\_

□Concussion\_\_\_\_\_\_\_\_

If so, how many?\_\_\_\_\_\_\_\_

□Head Injury\_\_\_\_\_\_\_\_

□Head Aches\_\_\_\_\_\_\_\_

□Migraines

With or without aura?\_\_\_\_\_\_\_

□Learning Disabilities\_\_\_\_\_\_\_\_\_

□Memory Problems\_\_\_\_\_\_\_\_\_\_\_\_

□Multiple Sclerosis\_\_\_\_\_\_\_\_\_\_\_

□Motion Sickness\_\_\_\_\_\_\_\_\_\_\_

□Nervous System Problems\_\_\_\_\_\_\_

□Numbness or Tingling \_\_\_\_\_\_\_\_

□Parkinson’s \_\_\_\_\_\_\_\_\_\_\_

□Seizures\_\_\_\_\_\_\_\_\_\_

□Meningitis\_\_\_\_\_\_\_\_\_\_\_\_

□Arthritis\_\_\_\_\_\_\_\_\_\_\_\_

□Back Pain\_\_\_\_\_\_\_\_\_\_\_\_\_

□Broken Bones\_\_\_\_\_\_\_\_\_\_

□Gout\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Joint Disease/Pain\_\_\_\_\_\_\_\_\_\_\_

□Muscle Injury\_\_\_\_\_\_\_\_\_\_

□Osteoporosis\_\_\_\_\_\_\_\_\_\_\_\_\_

□Stiff neck/Pain\_\_\_\_\_\_\_\_\_\_

□Metal Implants\_\_\_\_\_\_\_\_\_\_\_\_

□ Other Muscular Skeletal Issues\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_

□Persistent Thirst\_\_\_\_\_\_\_\_\_\_\_

□Thyroid Problems\_\_\_\_\_\_\_\_\_\_\_\_

Hypo or Hyper\_\_\_\_\_\_\_\_\_\_\_

□Immune Problems\_\_\_\_\_\_\_\_\_\_\_\_

□Bladder Infections\_\_\_\_\_\_\_\_\_\_\_\_

□HIV/AIDS\_\_\_\_\_\_\_\_\_\_\_\_

□Lupus\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Measles\_\_\_\_\_\_\_\_\_\_\_

□Malaria\_\_\_\_\_\_\_\_\_\_\_\_

□Mumps\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Polio\_\_\_\_\_\_\_\_\_\_\_\_\_

□Scarlet Fever\_\_\_\_\_\_\_\_\_\_\_\_

□Cold Sores\_\_\_\_\_\_\_\_\_\_\_\_

□Cancer\_\_\_\_\_\_\_\_\_\_\_\_

□Addictions\_\_\_\_\_\_\_\_\_\_\_

□Alcoholism\_\_\_\_\_\_\_\_\_\_\_

□Anxiety/Panic Attacks\_\_\_\_\_\_\_\_

□Depression\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Eating Disorders\_\_\_\_\_\_\_\_\_\_\_

□Emotional Problems\_\_\_\_\_\_\_\_\_\_\_

□Mental Illness\_\_\_\_\_\_\_\_\_\_\_\_

□Skin Cancer\_\_\_\_\_\_\_\_\_\_\_

□Blistering Sunburn\_\_\_\_\_\_\_\_\_\_

□New Moles\_\_\_\_\_\_\_\_\_\_

Men’s Health

□Bladder Infections\_\_\_\_\_\_\_\_\_\_\_\_\_

□Prostate Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Problems Urinating\_\_\_\_\_\_\_\_\_\_\_\_\_

□Sexually Transmitted Infections\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Infertility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Testicular Pain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women Health

□Abnormal Pap\_\_\_\_\_\_\_\_\_\_

□Abnormal Periods\_\_\_\_\_\_\_\_

□Gynecological Problems\_\_\_\_\_\_\_\_\_

□Pain with Sex\_\_\_\_\_\_\_\_\_\_\_\_

□Irregular Vaginal Bleeding\_\_\_\_\_\_\_\_\_

□Ovarian Cancer

□Any Gynecological Cancer\_\_\_\_\_\_\_\_\_\_\_\_

□If Menopausal, any Vaginal Bleeding\_\_\_\_\_\_\_\_\_\_\_

□Pregnancy Problems\_\_\_\_\_\_\_\_\_\_\_\_

□Infertility

□Sexually Transmitted Infections\_\_\_\_\_\_\_\_

#Pregnancies \_\_\_\_\_ #Deliveries\_\_\_\_\_\_ #Abortions\_\_\_\_\_\_ #Miscarriages\_\_\_\_\_

1st day of most recent period\_\_\_\_\_\_\_\_\_\_ Age at 1st period\_\_\_\_\_\_\_\_\_\_

Frequency of periods\_\_\_\_\_\_\_\_\_\_\_ Length of each\_\_\_\_\_\_\_\_\_\_\_

Any concerns about your periods? □Yes □No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any concerns about Menopause? □Yes □No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History**

Please list any family members who have had the following

|  |  |  |  |
| --- | --- | --- | --- |
| Problem | Family Member | Details | Age Deceased  (if applies) |
| High Blood Pressure |  |  |  |
| High Cholesterol |  |  |  |
| Heart Attack |  | (age) |  |
| Asthma |  |  |  |
| COPD |  |  |  |
| Lung Cancer |  |  |  |
| Sleep Apnea  Other Respiratory Disease |  |  |  |
| Stroke |  |  |  |
| Blood clots/Bleeding disorder |  |  |  |
| Migraines  Other Neurologic Conditions |  |  |  |
| Glaucoma |  |  |  |
| Breast Cancer |  | (age) |  |
| Ovarian Cancer |  | (age) |  |
| Colon Cancer/Polyps |  | (age) |  |
| Diabetes |  |  |  |
| Thyroid |  |  |  |
| Bone or Joint Problems |  |  |  |
| Depression/Anxiety |  |  |  |
| Autism |  |  |  |
| Alcoholism |  |  |  |
| Any of Cancer |  |  |  |
| Dementia |  |  |  |
| Schizophrenia |  |  |  |
| Bipolar |  |  |  |
| Skin Cancer |  |  |  |

Any Other Family Conditions You Feel I Should Know About:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History and Lifestyle**

Relationship Status: □Married/Partnered □Single □Separated □Divorced □Widowed

Do you have children? □Yes □No

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lives at Home? □Yes □No

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lives at Home? □Yes □No

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lives at Home? □Yes □No

Who also lives with you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any pets? □Yes □No Do they live inside □Yes □No

Have you ever been neglected or abused physically, emotionally, or sexually?

Is your current living situation safe? □Yes □No

Do you have more than one sexual partner? □Yes □No

Sexual Partner: □Men □Women □Both □Not sexually active

Do you practice safe sex? (ex. Condoms) □Yes □No

Are you interested in being tested for sexually transmitted infections? □Yes □No

Are you using birth control? If so what type? □Yes □No Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wish to become pregnant? □Yes □No

On average, how many alcoholic drinks do you consume per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use or have you ever used tobacco products? \_\_\_\_\_\_\_\_\_\_\_\_ If so how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone smoke around you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wish to quit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you tried to quit in the past? □Yes □No How many times? \_\_\_\_\_\_\_\_What methods have you tried?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use or have you ever used recreational drug? □Yes □No

How much caffeine do you consume daily? (coffee, soda, etc).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have concerns about your diet? □Yes □No If so, what are they\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? □Yes □No, If so what and how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have: □ Living will □ Power of attorney □Durable power of attorney for healthcare

Would you like information on these? □Yes □No