YOUR PERSONAL HABITS	YES	NO	PLEASE DESCRIBE
Regularly exercise (3 or 4 times/wk)	☐	☐	________________
Caffeine intake (coffee, tea, sodas)	☐	☐	________________
Wear seat belts (90% of the time)	☐	☐	________________
Use illegal drugs	☐	☐	________________
Use alcohol	☐	☐	________________
Were you ever a heavy drinker?	☐	☐	________________
Do you smoke?	☐	☐	________________

If ever, when did you stop? ______________________

FAMILY HISTORY	YES	NO
1. Diabetes	☐	☐
2. Asthma	☐	☐
3. Cancer	☐	☐
4. Cystic Fibrosis	☐	☐
5. Muscular Dystrophy	☐	☐
6. Heart Disease	☐	☐
7. High Blood Pressure	☐	☐
8. Sickle Cell Anemia	☐	☐
9. Anesthetic Reaction	☐	☐
10. Blood Disorder	☐	☐
11. Thyroid Disorder	☐	☐
12. Stroke	☐	☐
13. Kidney Disease	☐	☐
14. Arthritis	☐	☐
15. Tuberculosis	☐	☐
16. Psychiatric Disease	☐	☐

1. Which relatives have significant medical problems?

____

2. Your Father ☐ Alive ☐ Dead
Cause of Death: ______________ Age: _________

3. Your Mother ☐ Alive ☐ Dead
Cause of Death: ______________ Age: _________

4. Your Brothers: No. Alive _____ No. Dead _______
Cause of Death: _____________ Age: _________

5. Your Sisters: No. Alive _____ No. Dead _______
Cause of Death: _____________ Age: _________

TESTS (Give date last done)

	YES	YEAR DONE	NOT SURE	NEVER
1. Chest X-ray	☐	____________	☐	☐
2. EKG	☐	____________	☐	☐
3. Hearing Test	☐	____________	☐	☐
4. Vision Test	☐	____________	☐	☐
5. Treadmill Stress Test	☐	____________	☐	☐
6. Pulmonary Function Test	☐	____________	☐	☐
7. Sodium & Potassium	☐	____________	☐	☐
8. Cholesterol / Triglycerides	☐	____________	☐	☐
9. CBC	☐	____________	☐	☐
10. Fasting Blood Sugar	☐	____________	☐	☐
11. Thyroid Profile	☐	____________	☐	☐
12. Prostate Specific Antigen (Men)	☐	____________	☐	☐
13. Urine Test	☐	____________	☐	☐
14. Stool Occult Blood	☐	____________	☐	☐
15. Pap Smear (Women)	☐	____________	☐	☐
16. Breast Exam	☐	____________	☐	☐
17. Breast Mammography	☐	____________	☐	☐
18. Rectal Exam	☐	____________	☐	☐

WOMEN ONLY:

First day of last menstrual period: ___________________ Date of prior period (previous to last): ________________

Periods: Age of onset __________ Periods: ☐ Regular or ☐ Irregular Duration: ____ days; Heavy ____ Light ____

Type of Contraception: ____

Pregnancies: Number of Pregnancies: __________ Live Term Births: ______________ Premature: ______________

Number of Stillborns: ____________ Miscarriages: _________________ Abortions: ______________

Children Still Living: _____________ Number of Cesarean Sections: ____________________________