LIFESTYLE HISTORY

PATIENT NAME:_____ **Date of birth**_____/____/_____

Immunization history: Have you had?

	Yes	No	If yes, when	
Hepatitis B				
Pneumovax				
Flu				
Tetanus				
Other:				

When was your last?	
	DATE
Pap/Breast exam	
Stool check	
Colonoscopy	
Mammogram	
Cholesterol check	

What is your method of birth control?_____

	Yes	No
If you are a woman, do you perform a monthly breast self-exams?		
If you are a man, do you perform monthly testicular self-exams?		

PREVENTION:	YES	NO
Do you wear seatbealt?		
Do you wear a bike helmet?		
Do you use tobacco products?		
Do you drink alcohol?		
Do you drink caffeinated drinks?		
Do you have these in your home?		
1. Smoke detector		
2 Carbon Monoxide detector		
3. Gun		

If no,when did you stop?_____**How long did you use?**_____

If yes,how much per week? CIRCLE BELOW

1-3/week	1-2/day	>3per day	
If yes,how many per day? 1 - 2			>5

_____

If yes, is it secured ?

SOCIAL HISTORY

Do you now, or have you in the past, used illegal drugs? **If yes,explain:**_____

Have you ever engaged in any activity which has put you at risk of gettting AIDS OR HEPATITIS C?

(including gay,mutiple partner,IV drug use) _____**no** _____**yes** **If yes, explain:**_____

Do you wish to be tested for AIDS or Hepatitis C? _____**no** _____**yes**

Are you in a relationship in which you have been physically hurt or threatened by your partner? ___**no**____**yes**

Have you ever worked with chemicals,paints,asbestos or other hazardous material? ___**no**___**yes**

If yes, explain:_____

Do you have a "LIVING WILL"?____**no**____**yes** **Are you an organ donor?**___**no**____**yes**

What is your method of birth control?_____

age at your first period:_____

If you are a woman, do you perform monthly breast self-exams? _____**yes**_____**no**

If you are a man, do you perform monthly testicular self-exams? _____**yes**_____**no**

PAST MEDICAL HISTORY

Have any members of your family (parents, grandparents, & siblings) ever had any of the following

	Patient	Family member	relation	age diagnosed
Thyroid Disease				
Osteoporsis				
Cancer(describe type)				
Heart disease				
Hypertention				
Disbetes				
Strokes				
Mental Disease (anxeity, depression, etc.)				
Drug addiction				
Alcohol addiction				
Bleeding/Clotting disorders				

Other:				

Please ask provider during visit if you would like information regarding advanced directives.