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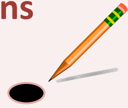
Using Adobe Acrobat Reader 8.0 or later

Initial Health History

Please answer every question

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval
as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

PATIENT MEDICAL HISTORY

Please indicate if YOU have a history of any of the following. Mark all that apply. If none, mark "NONE."

- Abnormal heart rhythm or EKG
- Anxiety
- Arthritis
- Asthma
- Blood clots
- Blood disease
- Cancer (any kind)
- Congestive heart failure
- Convulsions or epilepsy
- Depression
- Diabetes
- Emphysema
- Heart attack
- Heart murmur
- Heart valve disease
- Hepatitis
- High blood pressure
- High cholesterol or triglycerides
- Kidney disease
- Leg circulation problem
- Liver disease
- Lung disease
- Prostate disease
- Psychiatric disease
- Rheumatic fever
- Sleep apnea
- Stomach ulcers
- Stroke
- TIA
- Thyroid disease
- Tuberculosis
- Valvular heart disease
- Varicose veins
- Vascular disease
- Other
- NONE

SURGICAL HISTORY

Please indicate if YOU have a history of any of the following surgeries. Mark all that apply. If none, mark "NONE."

- Aneurysm repair
- Aortic aneurysm
- Appendectomy
- Bariatric surgery
- Blood vessel surgery
- Breast surgery
- Cataract surgery
- Carotid surgery
- Coronary surgery
- Defibrillator implant
- Gallbladder surgery
- Heart angioplasty / stent
- Heart valve surgery
- Hernia repair
- Hysterectomy
- Organ transplant
- Orthopedic surgery
- Ovaries removed
- Pacemaker implant
- Plastic surgery
- Prostate surgery
- Vascular surgery
- Other
- NONE

PATIENT STATUS

Please indicate YOUR current living situation.

- Living alone
- Living with family / friends
- Living with spouse / significant other
- Living in an assisted living facility

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Initial Health History

Please answer every question

FAMILY MEDICAL HISTORY

Please indicate which family member(s) have had these illnesses. Mark all that apply. If none, mark "NONE."

- FAMILY HISTORY UNKNOWN

	Father	Mother	Sibling	NONE
Abnormal heart rhythm				
Congenital heart disease				
Diabetes				
Heart disease				
Stroke				
Sudden death				
Valve disease				
None of the above illnesses				

- Mother, grandmother, or sister developed heart disease before the age of 65
- Father, grandfather, or brother developed heart disease before the age of 55

TOBACCO USE

How would you describe your cigarette smoking?
current (every day) · current (some days) · previous · never

If you are a FORMER smoker, when did you quit?
within the last month · more than 1 year ago

How many packs per day do you (or did you) smoke?
never · less than 1 · 1-2 · 2-3 · 3-4

Smoking cessation:
not applicable · want to quit now / need help · not yet ready to quit · do not want to quit

Are you exposed to passive (second hand) smoke? yes · no

ALCOHOL USE

How often do you consume alcohol?
never · rarely · sometimes · frequently

Number of drinks: 1-2 · 3-4 · 5-6 · 7+

Frequency: monthly · weekly · daily

DRUG USE

none · currently · previously · prefer to discuss with physician

HABITS

Type(s) of caffeine: none · coffee · tea · soft drinks

Number of caffeine drinks per day:
occasionally · 1-2 · 3-4 · 5-6 · 7+ · none

Exercise - Type(s) of exercise:
bicycling · walking · running · swimming · aerobics · other

Number of times you exercise per week:
occasionally · 1-2 · 3-4 · 5-6 · 7+ · none

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