NAME:____ DATE:___________________

PATIENT HISTORY QUESTIONNAIRE

MARITAL STATUS:

Married_____ Single____ Divorced____ Separated____ Widowed____

EDUCATION:

Last school grade completed?____

OCCUPATION:____
RETIRED: Yes___ No___

GENERAL:

Do you limit sun exposure and/or use sun protection (SPF lotion or protective clothing)?
Yes___ No___

Do you use vehicle safety belts? Yes___ No___

Does your home have smoke alarms? Yes___ No___

Do you have a living will/medical power of attorney? Yes___ No___ (If answered "Yes" a copy is required for your medical records)

Do you know and practice safe sex? Yes___ No___ (Information on avoiding sexually transmitted diseases is available upon request.)

What method(s) of family planning/birth control do you use?
____
____

Do you do self-prescribed self-examinations regularly? Yes___ No___ (MALES: Testicular self-exams; FEMALES: Breast self-exams)

FEMALE ONLY:
Date of last Pap Test:____
Last Period/Menstruation:____
Number of Pregnancies:____
Number of living children:____

NAME: ____ DATE: ____________________

PATIENT HISTORY

MEDICATIONS: (Please list all medication you are currently taking.)

1.____________________________________ 5.____________________________________

2.____________________________________ 6.____________________________________

3.____________________________________ 7.____________________________________

4.____________________________________ 8.____________________________________

FAMILY HISTORY:

	AGE	GENERAL HEALTH	LIVING/DECEASED
Father:			
Mother:			
Brothers:			
Sisters:			
Children:			

LAST EKG, X-RAYS, SCANS:

PRIOR ILLNESSES OR SURGERIES:

PERSONAL HABITS:

Smoke__________________________ How much / How long?_______________________

Alcohol________________________ How much / How long?_______________________

Illegal Drugs____________________ How much / How long?_______________________

Coffee_______ How much / How long?___________Type of Work___________________

KNOWN DRUG ALLERGIES: