

YOUR PERSONAL HABITS

YES NO

PLEASE DESCRIBE

- Regularly exercise (3 or 4 times/wk) YES NO
- Caffeine intake (coffee, tea, sodas) YES NO
- Wear seat belts (90% of the time) YES NO
- Use illegal drugs YES NO
- Use alcohol YES NO
 - Were you ever a heavy drinker? YES NO
- Do you smoke? YES NO
 - If ever, when did you stop? _____

FAMILY HISTORY

YES NO

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

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 YES
- 2. EKG YES
- 3. Hearing Test YES
- 4. Vision Test YES
- 5. Treadmill Stress Test YES
- 6. Pulmonary Function Test YES
- 7. Sodium & Potassium YES
- 8. Cholesterol / Triglycerides YES
- 9. CBC YES
- 10. Fasting Blood Sugar YES
- 11. Thyroid Profile YES
- 12. Prostate Specific Antigen (Men) YES
- 13. Urine Test YES
- 14. Stool Occult Blood YES
- 15. Pap Smear (Women) YES
- 16. Breast Exam YES
- 17. Breast Mammography YES
- 18. Rectal Exam YES

NOT SURE

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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: _____