Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions.

Direction of Feed

Patient History

Please answer every question

*Handwritten items must be entered **MANUALLY**. Fold only on the dotted lines.*

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

PAST MEDICAL HISTORY

Please indicate if YOU have had any of the following. Mark all that apply.

- ◯ **NONE**
- ◯ Acid Reflux / GERD
- ◯ Alcohol Abuse
- ◯ Anxiety
- ◯ Arthritis
- ◯ Asthma
- ◯ Atrial Fibrillation
- ◯ Back Pain
- ◯ Heart Failure
- ◯ Heart Murmur
- ◯ Hemorrhoids
- ◯ Hepatitis
- ◯ Hernia (inguinal)
- ◯ Hernia (umbilical)
- ◯ Hernia (ventral)
- ◯ High Blood Pressure
- ◯ Stomach Ulcer
- ◯ Stroke / TIA
- ◯ Thyroid Problems
- ◯ Ulcerative Colitis
- ◯ Vascular Disease
- ◯ **Other Significant Medical Illness:** _____

please fold on dotted line

- ◯ Bladder Problems
- ◯ Breast Mass
- ◯ Chest Pain
- ◯ Cirrhosis
- ◯ Crohn's Disease
- ◯ COPD
- ◯ Depression
- ◯ Diabetes
- ◯ Diverticulosis
- ◯ Emphysema
- ◯ Enlarged Prostate
- ◯ Gallstones
- ◯ Heart Attack
- ◯ High Cholesterol
- ◯ History of Blood Transfusions
- ◯ HIV Positive
- ◯ Home Oxygen Use
- ◯ Kidney Failure
- ◯ Kidney Stones
- ◯ Migraines
- ◯ Pancreatitis
- ◯ Problems with Anesthesia
- ◯ Pulmonary Embolism / Blood Clot in Legs
- ◯ Seizures
- ◯ Sickle Cell Disease
- ◯ Sleep Apnea

Cancer:

- ◯ Breast
- ◯ Cervical
- ◯ Colon
- ◯ Lung
- ◯ Melanoma / Skin
- ◯ Ovarian
- ◯ Pancreatic
- ◯ Prostate
- ◯ Rectal
- ◯ Thyroid
- ◯ Other Cancer: _____

Have you had a colonoscopy: ◯ within last year ◯ 1-5 years ago ◯ 5-10 years ago ◯ >10 years ago ◯ never

REPRODUCTIVE HISTORY (WOMEN ONLY)

Age at first period: ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17

Are your periods regular? ◯ yes ◯ no

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Contraceptive history: ◯ oral contraceptive pills ◯ contraceptive implant ◯ contraceptive injection ◯ progesterone IUD

If you have gone through menopause, what age were you? ◯ <45 ◯ 46-50 ◯ 51-55 ◯ 56-60 ◯ >60

Number of pregnancies: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Number of live births ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Age at first pregnancy: ◯ <15 ◯ 15-20 ◯ 21-25 ◯ 26-30 ◯ 31-35 ◯ 36-40 ◯ >40

If you had children and breastfed them, how many months did you breastfeed? ◯ 3-6 ◯ 7-12 ◯ 12-24 ◯ >24

Have you had a mammogram: ◯ within last year ◯ 1-3 years ago ◯ >3 years ago ◯ never

Have you had a pap smear: ◯ 1-5 years ago ◯ >5 years ago ◯ never

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Direction of Feed

Patient History

Please answer every question

*Handwritten items must be entered **MANUALLY**. Fold only on the dotted lines.*

SOCIAL HISTORY

Smoking:	never smoked	currently smoke (some days)
	former smoker	currently smoke (every day)
Alcohol:	never	heavily
	occasionally	quit recently
	moderately	quit a long time ago
Caffeine:	none	tea
	coffee	carbonated beverages
Illicit drugs:	never	yearly
	socially only	quit recently
	daily	quit a long time ago
	weekly	
	monthly	prefer to discuss with provider

please fold on dotted line

FAMILY MEDICAL HISTORY

Please indicate which family members have had these illnesses:

Family History Unknown NONE

	Father	Mother	Brother	Sister	Son	Daughter	Other
Alcohol Abuse							
Anesthetic Complication							
Arthritis							
Bleeding Disorder (such as Anemia)							
Breast Cancer							
Cervical Cancer							
Colon Cancer							
Colon Polyps							
Depression							
Diabetes							
Heart Disease							
High Blood Pressure							
Kidney Disease							
Lung / Respiratory Disease							

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Melanoma							
Migraines							
Ovarian Cancer							
Pancreatic Cancer							
Prostate Cancer							
Rectal Cancer							
Seizures / Convulsions							
Stroke / CVA of the Brain							
Thyroid Problems							
Other Bowel Disease							
Other Cancer							

- Mother, Grandmother, or Sister developed heart disease before the age of 65
- Father, Grandfather, or Brother developed heart disease before the age of 55

SURGICAL HISTORY

Please mark all surgeries you have had:

- ◯ **I Have Had No Surgeries**

- ◯ Anal Fissure Repair
- ◯ Aneurysm Repair
- ◯ Appendectomy
- ◯ Bypass Surgery for Poor Blood Flow to Legs
- ◯ Dialysis Shunt / Fistula
- ◯ Heller Myotomy
- ◯ Hemorrhoidectomy
- ◯ Liver Surgery
- ◯ Nissen Fundoplication
- ◯ Oral Surgery
- ◯ Pancreas Surgery
- ◯ Sentinel Lymph Node Biopsy
- ◯ Small Bowel Surgery
- ◯ Splenectomy
- ◯ Stomach Surgery
- ◯ Thyroid Surgery
- ◯ Tonsillectomy
- ◯ Vasectomy

please fold on dotted line

	Left	Right	Both	Multiple Times
Carotid Artery Surgery	◯	◯	◯	◯
Laparoscopic Inguinal Hernia Surgery	◯	◯	◯	◯
Open Inguinal Hernia Surgery	◯	◯	◯	◯
Ventral / Umbilical Hernia Surgery	◯	◯	◯	◯
Breast Biopsy	◯	◯	◯	◯
Breast Cancer Lump Removal	◯	◯	◯	
Mastectomy	◯	◯	◯	
Breast Augmentation	◯	◯	◯	
Breast Reconstruction	◯	◯	◯	
Breast Reduction	◯	◯	◯	
Cataract Surgery	◯	◯	◯	
Foot Surgery	◯	◯	◯	
Hip Surgery	◯	◯	◯	
Kidney Removal	◯	◯	◯	
Knee Surgery	◯	◯	◯	
Lung Surgery	◯	◯	◯	
Ovary Removal	◯	◯	◯	
Shoulder Surgery	◯	◯	◯	

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Caesarean Section	◯ 1	◯ >1
Colon Polyp Removal	◯ Open	◯ Colonoscopy
Colon Removal	◯ Partial	◯ Complete
Gallbladder Surgery	◯ Open	◯ Laparoscopic
Heart	◯ Bypass	◯ Valve
Hysterectomy (due to cancer)	◯ Partial	◯ Complete
Hysterectomy (not due to cancer)	◯ Partial	◯ Complete
Prostate Surgery	◯ TURP	◯ Prostatectomy
Spinal Surgery	◯ Neck ◯ Mid Back	◯ Lower Back
Weight Loss Surgery	◯ Gastric Bypass ◯ Lapband Surgery	◯ Sleeve Gastrectomy