

CHECK ANY THAT APPLY AND LIST IF YOUR BLOOD RELATIVES HAVE HAD:

Major Illnesses	Yes	What Blood Relative?	Mother's	Father's
Anemia				
Arthritis / Joint Pain				
Asthma				
Bowel Troubles / Ulcers				
Breast Cancer				
Cancer				
Chronic Lung Disease				
Depression / Anxiety / Mood Disorders				
Diabetes				
Glaucoma				
Heart Trouble / Murmur				
Hepatitis / Jaundice				
High Blood Pressure				
High Cholesterol				
Kidney Infections / Stones				
Stroke				
Thyroid Disease				
Tuberculosis - TB				
Other:				

SOCIAL HISTORY

Do you exercise? None Less than 3 times per week More than 3 times per week

Do you have sex with: Men Women Both

First Intercourse at age: _____ New sexual partner? Yes No

Lifetime sexual partners Less than 5 More than 5

Do you have any sexual problems you want to discuss today? Yes No

Describe: _____

Do you want to be screened for HIV/AIDS? Yes No (This screening is NOT covered by insurance.)

Do you want to be screened for other STD's? Yes No

Have you ever had a blood transfusion? Yes No Date: _____

Smoking: Yes No Previously Packs per day _____ # of years _____ Stopped _____ Years Ago

Alcohol Yes No Previously Drinks per day _____ Drinks per week _____

Caffeine Yes No Drinks per day _____ Drinks per week _____

Drug user Yes No Previously Kind/Type _____ Frequency _____

History of Abuse Yes No Physical Emotional Sexual

Are you in a relationship with someone who physically threatens or hurts you? Yes No

List all "Natural" or "Herbal" remedies, over the counter drugs, vitamins, or minerals you are taking: _____

Highest Grade Completed in School: GED High School Attended Some College

Associate Degree (2 years) Bachelor's Degree (4 years) Post-Graduate

Some Graduate Work Did not attend school Did not complete high school

Other: _____

Occupation: _____

Race: White African American Hispanic Asian Other _____

Marital Status: Single Engaged Married Divorced Widowed