

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Today's Date: \_\_\_\_\_

ALLERGY – History of allergy to drugs, foods, and/or environment \_\_\_\_\_

---

**HABITS:**

Cigarettes                      How many per day? \_\_\_\_\_      How many years? \_\_\_\_\_  
Pipe/Cigar                      How many bowls? \_\_\_\_\_      How many years? \_\_\_\_\_  
Chewing tobacco              How many pouches? \_\_\_\_\_      How many years? \_\_\_\_\_  
Alcohol                      Do you drink daily? \_\_\_\_\_  
                                    How many drinks do you average a week? \_\_\_\_\_  
                                    What is the most drinks you had one any ONE occasion in the past month? \_\_\_\_\_  
                                    Have you ever tried to cut down on how much you drink? \_\_\_\_\_  
                                    Have you ever annoyed people with your drinking or been criticized you about  
                                    your drinking? \_\_\_\_\_  
                                    Have you ever felt bad or guilty about your drinking? \_\_\_\_\_  
                                    Have you ever used an “eye-opener” to steady your nerves in the morning or treat  
                                    a hangover with a first morning drink? \_\_\_\_\_  
Do you use illicit drugs (marijuana, cocaine, crack, etc.)? \_\_\_\_\_

**RISK FACTORS/LIFESTYLE:**

Circle the risk factors/lifestyles that apply to you.

**ATHEROSCLEROTIC DISEASE**

Known disease (have you had a heart attack or stroke?) ..... Yes No  
Are you male? ..... Yes No  
Family history of heart attacks..... Yes No  
Do you have high blood pressure? ..... Yes No  
Do you have diabetes mellitus? ..... Yes No  
Do you have high LDL? ..... Yes No  
Do you have high HDL? ..... Yes No  
Are you sedentary (do you exercise less than 20 minutes 3 times a week?)..... Yes No  
Do you use tobacco? ..... Yes No  
Are you obese?..... Yes No  
Are you a male 45 years or older? ..... Yes No  
Are you a female 55 years or older? ..... Yes No

**CANCER**

Breast:  
Family history of breast cancer (mother/sister)..... Yes No  
Menarche (start of period) 12 years old or younger ..... Yes No  
Late menopause (stop menstruation older than 55)..... Yes No  
Never pregnant or first pregnancy older than 36 years old? ..... Yes No  
Have you ever breast fed? ..... Yes No