

Patient Name: _____
Today's Date: _____

DOB: _____

COLON:

Family history of colon cancer(parents/siblings) Yes No
Family history of colon polyps..... Yes No

LUNG:

SmokerYes No
Environmental tobacco smokeYes No
Chemical exposure at work.....Yes No
Radon.....Yes No

INJURIES/OTHER:

Family history of COPD/emphysemaYes No
Family history cirrhosisYes No
Family history alcoholism, drugsYes No
Family history suicide, depressionYes No
Personal history depression, helplessness, disappointmentYes No
Is there a person in your life who shows a pattern of control: where you go, what you do,
and who you are with?Yes No
Do you feel safe going home? Do you feel safe in your house?.....Yes No
Have you been physically abused: hit, kicked, choked, burned, etc.....Yes No
Have you ever been verbally abused: threatened, cursed, isolated, told you were
worthlessYes No
Have you ever been sexually abused: made to have sex, made to have sex that you did not
want to do, touched, etc.....Yes No
Personal history of violence/arrestYes No
Own firearms (gun, rifle)Yes No
Exposure poisons, chemicals, work/farm/homeYes No
High risk sexual activities (more than one partner, or partner of the same sex).. Yes No
History of viral hepatitisYes No
Drive your car more than 10,000 miles per yearYes No
Do you wear your seat belts at all times?Yes No
Do you have working smoke detectors?Yes No
Do you have a fire extinguisher?Yes No
Do you have a fire escape for your house?Yes No
Do you know your basic fire safety rules?Yes No

FAMILY HISTORY:

DiabetesYes No
HypertensionYes No
StrokeYes No
Heart diseaseYes No