



**MEDICAL HISTORY**

NONE

Please check any physical or mental health conditions (or problems) you have now or have ever had. Add the year it started, if known. Please add any other conditions if not listed.

✓	DATE	CONDITION	✓	DATE	CONDITION	✓	DATE	CONDITION
		Asthma			Heartburn, GERD or Reflux			Pain all the time (Chronic)
		Bleeding (excessive or easy)			Heart Disease			Sleep Apnea
		Cancer			Hepatitis C			Stroke
		COPD (lung disease-chronic)			HIV/AIDS			
		Depression			Hypertension (high blood pressure)			
		Diabetes			Kidney Dialysis			
		Epilepsy or seizures			Neuromuscular Disease			

Have you had any serious injuries or accidents or hospital stays? Please list with the date, if known.

DATE	DESCRIPTION

**SURGICAL HISTORY (AND PROCEDURES)**

NONE

Do you have any metal or plastic implants?  Yes –  valves  rods  pins  shunt  fistula  
 pacemaker or other heart device  cardiac stent

Have you had an organ or tissue transplant?  Yes – What organ/tissue? \_\_\_\_\_

Have you ever had –  abnormal EKG  abnormal Chest X-Ray  problems with anesthesia  blood transfusion

Please list any surgeries or procedures you have had. Add the date if you know it.

DATE	SURGERY OR PROCEDURE	DATE	SURGERY OR PROCEDURE	DATE	SURGERY OR PROCEDURE

**FAMILY HISTORY**

NONE

Please list those in your family who have or have had the following:

Relationship	Name	Status Alive		Cancer	Depression	Diabetes	Heart Attack (note age)	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Problems with Anesthesia	Details
		Yes	No										
Mother													
Father													
Sister													
Brother													

**SOCIAL / PERSONAL HISTORY**

Are you sexually active? Yes No Not Currently – Partners Female Male

Birth Control / Protection used: None Abstinence Pull Out Condom Injection Pills Patch

Insert / implant Type: \_\_\_\_\_ Rhythm Spermicide Surgical Other:\_\_\_\_\_

If female: Date of last menstrual period\_\_\_\_\_ Pregnant Yes No Breastfeeding Yes No

Do you use tobacco? Yes Never Quit – Quit Date\_\_\_\_\_ Chew/Snuff

Passive (Live with a smoker) – Name/Relationship\_\_\_\_\_

If yes – how many packs per day? less than 1 1 greater than 1 Other:\_\_\_\_\_

For how many years? less than 1 1-5 6-10 more than 10

Do you drink alcohol? No Quit (date)\_\_\_\_\_

Yes - Drinks per week: \_\_\_\_\_Glasses of wine \_\_\_\_\_Cans of Beer \_\_\_\_\_“Shots” or mixed drinks

Do you use drugs? No

Yes – Times per week:\_\_\_\_\_ Types: Marijuana Methamphetamines Cocaine IV

Other:\_\_\_\_\_

Would you like information about quitting? Yes No

Are you on special diet: No Yes Describe:\_\_\_\_\_

Have you lost more than 10 pounds in the last 6 months? Yes No

Do you snore loudly enough to be heard through a door? Yes No

Do you exercise regularly? Yes No If yes, How many times per week?\_\_\_\_\_ For how long?\_\_\_\_\_

Have you traveled outside the United States within last year? Yes No If yes, where?\_\_\_\_\_

Do you use help from a person(s) or equipment for everyday activities (bathing, dressing, etc.)? Yes No

Explain:\_\_\_\_\_

Do you use: Glasses Contact lenses Hearing aids False teeth Cane Walker Wheel chair

Do you live: Alone With others In a facility – name Other:\_\_\_\_\_

Are you a caregiver for: Children Parents Spouse Other:\_\_\_\_\_

Have you fallen in the last 3 months? Yes No

Do you feel safe at home? Yes No

NOTES:

Please read each section and match the answer to the amount of activity you are able to do –

Without stopping can you:
walk up 3 flights of steps or walk several blocks? <input type="checkbox"/> Yes <input type="checkbox"/> No
walk up more than 1 flight of steps or 2 blocks? <input type="checkbox"/> Yes <input type="checkbox"/> No
walk up one flight of steps or less. <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you get short of breath or have chest pain when lying in bed? <input type="checkbox"/> Yes <input type="checkbox"/> No

**NYHA CATEGORIES**

Symptoms = shortness of breath, angina

*Class 1 – No symptoms and no limitation in ordinary physical activity.*

*Class 2 – Mild symptoms and slight limitation during ordinary activity.*

*Class 3 – Marked limitation in activity due to symptoms.*

*Class 4 – Severe limitations. Experiences symptoms even while at rest.*

Why do you need to stop walking? (Check all that apply)

- Not applicable
- Chest pain/pressure
- Joint / back pain
- Muscle cramps
- Overweight
- Short of breath
- Weak, tired, dizzy

**HEALTH MAINTENANCE ACTIVITIES (BASED ON AGE).**

Please check if you have had the following tests or immunizations (vaccination/shot) and the date (if known).

✓	Date	Test	Normal	Abnormal	✓	Date	Immunization
		Cholesterol (Lipids)					Flu (Influenza)
		Sigmoidoscopy					Pneumonia
		Colonoscopy					Tetanus
		<b>If Male:</b> PSA					Hepatitis B
		<b>If Female:</b> Mammogram					
		Pap Smear					
		Dexascan					

Completed by \_\_\_\_\_ Date \_\_\_\_\_  
NAME/SIGNATURE

Interpreter present \_\_\_\_\_ Cyracom phone ID # \_\_\_\_\_  
NAME/SIGNATURE

Reviewed by \_\_\_\_\_ Entered into EMR Date \_\_\_\_\_  
NAME/SIGNATURE