

6. Do you drink coffee, tea, sodas or other caffeinated beverages? Yes No
 a. Number per day _____ or per week _____
7. Do you think you are at risk for HIV or other sexually transmitted disease? Yes No
8. Do you have an Advance Directive? Yes No
 (Please consider bringing a copy of any POA/Advanced directives for your provider to review)

FAMILY HISTORY

Family Member	Age	Alive/Deceased	Medical History	Cause of Death
Mother		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
Father		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
<input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
<input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
<input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
<input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
<input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
Maternal Grandmother		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
Maternal Grandfather		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
Paternal Grandmother		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
Paternal Grandfather		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
Other _____		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
Other _____		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
Other _____		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		

HEALTH MAINTENANCE: (month/day/year)

IMMUNIZATIONS: (month/day/year – last dose)

Colonoscopy/Sigmoidoscopy	/	/
Dental Exam	/	/
Eye Exam	/	/
Pap Smear	/	/
Breast Exam	/	/
Mammogram	/	/
Menstrual Period	/	/
PSA	/	/
Bone Density (DEXA)	/	/

Tetanus (Td or Tdap)	/	/
Influenza	/	/
Pneumonia	/	/
Shingles	/	/
MMR	/	/
Hepatitis B	/	/
Chicken Pox	/	/
PPD (TB Screening)	/	/

 Print Name & Signature

 Date