Welcome to our practice. We greatly appreciate your choosing us to provide care for your family. Our physicians will be asking you about your present medical condition and problems, but to allow us to learn more about you, please fill out this questionnaire. Although some questions may be a little startling, please understand that they address current health issues. For confidentiality, please complete the questionnaire in the exam room and give it to your physician. Once again, thank you for choosing our practice to handle your health care needs.

1. When was your last comprehensive health examination (blood tests, EKGs, etc.)?  
   Date: _____/_____/_____  
   Note: We recommend a comprehensive evaluation for healthy individuals every three years until age 40, every two years from ages 40 to 50 and annually after the age of 50. Patients with a chronic medical problem should have an annual health evaluation.

2. Do you have a family history of medical, mental or hereditary problems?  
   Please list: ____________________________________________

3. If you were born after 1957, have you had a second measles, mumps and rubella vaccination?  
   If you are at least 65 years old or have a chronic health problem, have you received the pneumococcal and flu vaccines?  
   Yes ☐  No ☐

4. If you are a female, do you do a monthly self-breast exam?  
   When was your last breast exam by your physician? Date: _____/_____/_____  
   Date of last mammogram: _____/_____/_____  
   Date of last pap smear: _____/_____/_____  
   Note: One out of every 10 women will get breast cancer. The best approach is early detection by doing a monthly self-breast exam, an annual breast exam by your physician and periodic mammograms.

5. If you are a male, do you do a monthly self-testicular exam?  
   Note: Testicular cancer is a leading cause of cancer for men under the age of 50.

6. Do you practice “safe sex”?  
   Are you at risk for AIDS?  
   Have you used illegal drugs?  
   Yes ☐  No ☐

7. What is your occupation? ____________________________________________  
   Have you ever been exposed to chemicals or radiation at the workplace?  
   Yes ☐  No ☐

8. Do you have a living will?  
   Yes ☐  No ☐

9. If there is a gun in your home, is it out of children’s reach and unloaded?  
   Yes ☐  No ☐

10. If you ride a bicycle, do you wear a bike helmet?  
    Yes ☐  No ☐

11. Is your home tobacco- and smoke-free?  
    Yes ☐  No ☐

12. Is your time well balanced between your job, family and hobbies?  
    Yes ☐  No ☐