IMMUNIZATIONS---When did you last have:

Tetanus Diptheria Immunization________________________ Pneumococcal vaccine (pneumonia)_____________
Skin Test for TB____________________________________ Hepatitis B vaccine_________________________
MMR____ Influenza vaccine__________________________

FAMILY HISTORY: Have any blood relatives (grandparents, parents, brothers, or sisters) had:

	Yes	No	Which relative, what age?
High blood pressure	( )	( )	___________________________________
Heart disease	( )	( )	___________________________________
Diabetes	( )	( )	___________________________________
Kidney Disease	( )	( )	___________________________________
Cancer	( )	( )	___________________________________
Suicide	( )	( )	___________________________________
Alcoholism	( )	( )	___________________________________
Other inheritable disease-- (such as hearing, neurological, blood disorders, etc.)	( )	( )	___________________________________

PERSONAL HISTORY

	Yes	No	
Have you ever smoked cigarettes?	( )	( )	How much?___________________________
Do you presently smoke?	( )	( )	How much?___________________________
Do you use alcoholic beverages regularly?	( )	( )	How much? _________________________
Do you use seat belts regularly?	( )	( )	
Do you use drugs for other than medical purposes?	( )	( )	Describe____________________________
Have you been a victim of sexual or physical abuse?	( )	( )	Describe____________________________
Are you depressed?	( )	( )	Why?___________________________
Does your home have working smoke detectors?	( )	( )	
Do you feel safe at home?	( )	( )	

HEALTH SCREENING—WOMEN

Do you examine your breasts for lumps?	( )	( )	
Have you had a Pap smear?	( )	( )	Date of last Pap__________________
Any history of abnormal Pap smear?	( )	( )	When?__________________________
Have you had a mammogram?	( )	( )	When/results?__________________

HEALTH SCREENING—MEN

Do you examine your testicles for lumps?	( )	( )
Have you had a prostate exam?	( )	( )
Trouble achieving or maintaining an erection?	( )	( )

HEALTH SCREENING—WOMEN AND MEN

Have you had your cholesterol checked?	( )	( )	Results__________________________
If you are over 50, have you had a flexible Sigmoidoscopy?	( )	( )	Results__________________________

Do you have a living will?	( )	( )