

| Allergies to medications | |
|--------------------------|------------------|
| Name the Drug | Reaction You Had |
| | |
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HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

| | | | | |
|------------------------|---|---------------------------------------|---|------------------------------|
| Exercise | <input type="checkbox"/> Sedentary (No exercise) | | | |
| | <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | |
| | <input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | |
| | <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | |
| | Rank salt intake | <input type="checkbox"/> Hi | <input type="checkbox"/> Med | <input type="checkbox"/> Low |
| | Rank fat intake | <input type="checkbox"/> Hi | <input type="checkbox"/> Med | <input type="checkbox"/> Low |
| | # of cups/cans per day? | | | |
| Alcohol | Do you drink alcohol? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | How many drinks per week? | | | |
| Tobacco | Do you use tobacco? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | <input type="checkbox"/> Cigarettes – pks./day | <input type="checkbox"/> Chew - #/day | <input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day | |
| | <input type="checkbox"/> # of years | <input type="checkbox"/> Or year quit | | |
| Drugs | Do you currently use recreational or street drugs? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Have you ever given yourself street drugs with a needle? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Personal Safety | Do you live alone? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Do you have frequent falls? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Do you have vision or hearing loss? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Do you have an Advance Directive and/or Living Will? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Would you like information on the preparation of these? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | AGE | SIGNIFICANT HEALTH PROBLEMS |
|----------------|--|-----------------------------|--|-----------------------------|
| Mother | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Father | | | | |
| Sibling | <input type="checkbox"/> M <input type="checkbox"/> F | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| | <input type="checkbox"/> M <input type="checkbox"/> F | | <input type="checkbox"/> M <input type="checkbox"/> F | |