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PERSONAL HISTORY AND HEALTH HABITS

Current Complaint/Illness:_____

_____

Year of Elementary		**Have you ever used tobacoo products?**	**Yes_____ No_____**
Years if High School		**Age Started_____ Age Quit_____**	**Pack Per Day_____**
Years of College		**Do you drink alcohol? Yes_____ No_____**	**How Much?_____**
Place of Birth		**Do you use recreational Drugs? Yes____ No____**	**What Type?_____**
Occupation		**Do you have any pets in your home? Yes___ No___**	**What Type?_____**
Hazard Exposures			

PLACE AN (X) ON THE FOLLOWING TESTS YOU HAVE HAD & DATE WHEN LAST DONE:

Chest X-Ray	Date:	**Mammogram**	Date:
Low Dose CT Chest	Date:	**Pap Smear**	Date:
Electrocardiogram	Date:	**RSV Vaccine**	Date:
Colonoscopy	Date:	**Flu Vaccine**	Date:
Cholesterol Panel	Date:	**Covid Vaccine**	Date:
Bone (Dexa) Scan	Date:	**Tetanus Vaccine**	Date:
Dermatology Exam	Date:	**Shingles Vaccine**	Date:
Eye Exam	Date:	**Pneumonia Vaccine**	Date:

PLACE AN (X) IF YOU HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

Allergy/Hay Fever		**Diabetes**		**Depression**	
Asthma/COPD		**Heart Disease**		**Anxiety/Panic Attacks**	
Acid Reflux/GERD		**High Blood Pressure**		**Scoliosis**	
Cancer		**High Cholesterol**		**Other:**	
Chronic Kidney Disease		**Stroke/Seizure**		**Other:**	