

Initial Health History

Please answer every question

FAMILY MEDICAL HISTORY

Please indicate which family member(s) have had these illnesses. Mark all that apply. If none, mark "NONE."

FAMILY HISTORY UNKNOWN

	Father	Mother	Sibling	NONE
Abnormal heart rhythm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Congenital heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sudden death	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Valve disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None of the above illnesses	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Mother, grandmother, or sister developed heart disease before the age of 65

Father, grandfather, or brother developed heart disease before the age of 55

TOBACCO USE

How would you describe your cigarette smoking?

current (every day) current (some days) previous never

If you are a FORMER smoker, when did you quit?

within the last month more than 1 year ago

How many packs per day do you (or did you) smoke?

never less than 1 1-2 2-3 3-4

Smoking cessation:

not applicable want to quit now / need help

not yet ready to quit do not want to quit

Are you exposed to passive (second hand) smoke?

yes no

ALCOHOL USE

How often do you consume alcohol?

never rarely sometimes frequently

Number of drinks:

1-2 3-4 5-6 7+

Frequency:

monthly weekly daily

DRUG USE

none currently previously prefer to discuss with physician

HABITS

Type(s) of caffeine:

none coffee tea soft drinks

Number of caffeine drinks per day:

occasionally 1-2 3-4

5-6 7+ none

Exercise - Type(s) of exercise:

bicycling walking running

swimming aerobics other

Number of times you exercise per week:

occasionally 1-2 3-4

5-6 7+ none