Who lives with you in your home? (spouse, children, in-laws, significant others, etc.)
Your Occupation: _____
What are your hobbies? _____
Birthplace: _____ Education: _____
Have you recently traveled outside of Texas? (If so, where?)
Do you get regular exercise: (describe):

Do you wear seat belts? (Circle one) Always Usually Occasionally Never

Smoking History: Check which one applies:
____ Never smoked
____ Previous smoker started (age) ____ Stopped (age) ____ On average how many packs per day? _____
_____ Current smoker: started (age) ____ on average, how many packs per day?

Do you drink wine, beer, or other alcoholic beverages? _____ if yes, how many times in the last year have you drank 4 or more drinks on one occasion? _____

Have you ever had a drinking problem? _____
How many cups of coffee or caffeinated drinks do you drink daily? ____
Do you use Marijuana, Cocaine, any street drugs/prescription drugs not prescribed for you? [ ] Yes [ ] No (Leave blank if you'd rather discuss with doctor)

Family History:

	Age If living	Age at death	Health problems or cause of death
Mother			
Father			
Brothers and sisters:			
Children:			

_____
Name of person/organization

Persons to Whom Information May be disclosed:
(Continued on next page) →

Please check whether or not you currently have (or had them in the past few weeks) these conditions:

	YES	NO
Fatigue		
Fever or chills		
Recent weight change		
Headache		
Vision problems		
Double vision		
Blurred vision		
Eye itching		
Eye pain		
Hearing loss		
Ear ache		
Ringing in ears		
Runny nose		
Nose bleeds		
Nasal congestion		
Snoring		
Hoarseness		
Sore throat		
Mouth sores		
Breast lump or pain		
Chest pain		
Irregular heart beat		
Pounding heart beat		
Shortness of breath		
Cough		
Wheezing		
Decreased appetite		
Increased appetite		
Difficulty swallowing		
Heartburn		
Nausea		
Vomiting		
Abdominal pain		

	YES	NO
Black tarry stools		
Rectal bleeding		
Diarrhea		
Constipation		
Blood in urine		
Urinating too often		
Too much urine		
Getting up at night to urinate		
Pain with urination		
Excessive thirst		
Weakness		
Easy bruising		
Muscle aches		
Joint pain		
Joint stiffness		
Swelling in arms or legs		
Dizziness		
Fainting		
Memory problems		
Numbness		
Anxiety		
Depression		
Trouble sleeping		
Hallucinations		
Dry skin		
itching		
Lump or spot on skin		
Rash		
Stress		

Men only:

	YES	NO
Straining with urination		
Pain or lump on testicle		
Discharge from penis		
Prostate problems		
Difficulty with erection		
Sexual difficulties		

Women only:
Date of last menstrual period:

	YES	NO
Pelvic pain		
Abnormal vaginal bleeding		
Vaginal discharge		
Sexual difficulties		

Past medical history: Please check whether you have ever had the following:

	Yes	No
Hypertension		
Diabetes		
Cancer		
Heart murmur		
Heart problems		
Asthma		
Emphysema or COPD		
Positive Skin test for TB		
Tuberculosis		
Blood clots		
Asbestos exposure		
Ulcers		
Colon polyps		
Gall bladder problems		
Hepatitis or jaundice		
Liver problems		

Check if you've had	VACCINATIONS:	Date of last one
	Tentanus	
	Influenza (Flu shot)	
	Influenza (H1N1)	
	Pneumonia	
	Hepatitis A	
	Hepatitis B	
	Shingles	
	Others? (list)	

	Yes	No
Pancreatitis		
Kidney problems		
Abnormal pap smear in past		
High PSA (men only)		
Seizure		
Depression or anxiety		
Stroke		
Blood problems		
Thyroid problems		
Arthritis		
Radiation treatments to head or neck		
Previous herpes, gonorrhea, Syphilis, or chlamydia		
HIV infection		
Other (list)		

Check if you've had	TESTS	DATE of last:
	Stool cards for colon cancer testing:	
	Colonoscopy	
	Sigmoidoscopy	
	Bone density	
	Mammogram	
	Pap smear (women only)	
	PSA (men only)	
	Eye exam by eye doctor	