

\_\_ Aceves

\_\_ Clothier

\_\_ Ozaeta

\_\_ Oltmann

\_\_ Nurse Only

\_\_ No Pref

\_\_ Pt Req

MRN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dignity Health Medical Group**

**Saint Francis/ St. Mary’s**

A service of Dignity Health Medical Foundation

|  |  |  |  |
| --- | --- | --- | --- |
| Name  Last: First: Middle: | | | |
| Sex: CIRCLE ONE  Female Male | Date of Birth:  / / | | Social Security Number: |
| Home Address:  Street:  City: State: ZIP: | | Mailing Address: (If different than home)  Street:  City: State: Zip: | |
| Phone: ( ) \_ \_ \_- \_ \_ \_ \_ | | Cell Phone: ( ) \_ \_ \_- \_ \_ \_ \_ | |
| Marital Status: Circle One  Single Married Divorced Widow | | Previous Last Name: | |
| **Race:**  \_\_ African American \_\_ American Indian/Alaska Native \_\_ Asian \_\_ Native Hawaiian / Other Pacific Islander  \_\_White \_\_ Other \_\_ Declined to State  **Ethnicity:**  \_\_ Hispanic, Latino, or Spanish Origin \_\_ Not Hispanic, Latino, or Spanish Origin \_\_ Declined to State  **Language:** | | | |
| Emergency Contact:  Name: Relationship: Phone: ( ) \_ \_ \_- \_ \_ \_ \_ | | | |
| **USF Student ID number:** | | | |
| Insurance Name and Address:  Insurance Phone # ( ) \_ \_ \_ - \_ \_ \_ \_ | | | |
| Policy Number (Certificate #, Member #, ID # )  Alfa prefix (if any) \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Suffix (if any) \_ \_ \_  Group # \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ | | | Subscriber Name and DOB: |
| Circle One: Self/Spouse/Child/ Other: |
| Name:  DOB: / / |
| **IF A MINOR, PERSON RESPONSIBLE FOR PAYMENT OF BILL** | | | |
| Name: Last First Middle | | | |
| DOB: | | | |
| Address: | | | |
| Phone: ( ) \_ \_ \_- \_ \_ \_ \_ Social Security Number: \_ \_ \_- \_ \_- \_ \_ \_ \_ | | | |
| Signature: Date: / / | | | |

Please describe how you heard about us:  USF  Mail Cards  Internet Friend/Family  Insurance Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dignity Health Medical Group Saint Francis/St. Mary’s

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**Portal Registration Consent**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name (if different)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: Self Primary Custodian (Primary Account Holder)

Dependent Child \*Custodian (Read Only Access)

Foster Child *\*Note: There can only be one primary custodian per*

*account*

Patient’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dignity Health Provider 1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dignity Health Provider 2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dignity Health Provider 3:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I AGREE** the email address given above is my personal email address to receive my PIN for access to the Dignity Health Online Patient Center. If I am not the patient, I certify that as a patient representative I am authorized to request this account be created for the patient named above.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OFFICE USE ONLY

I have verified by photo ID, this is the patient/Parent/Guardian.

Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have completed the initial patient registration.

Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dignity Health Medical Group**

**Saint Francis/ St. Mary’s**

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**CONFIDENTIAL HEALTH HISTORY**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_ Date of last physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the reason for today’s visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ILLNESSES**: Please indicate if you now have or had any of the following illnesses and the year that the condition began.

|  |  |  |
| --- | --- | --- |
| ALLERGIES | EMPHYSEMA | PROSTATE |
| ANEMIA | EPILEPSY/ SEIZURES | PSYCHIATRIC |
| ARTHRITIS | GOUT | SINUS PROBLEMS |
| ASTHMA | HEADACHE | SKIN DISEASE |
| BACK PROBLEMS | HEART DISEASE | STROKE |
| BLEEDING DISORDER | HEPATITIS | THYROID DISEASE |
| BRONCHITIS | HIGH BLOOD PRESSURE | TUBERCULOSIS |
| CANCER | HIGH CHOLESTEROL | ULCERS |
| BREAST | KIDNEY DISEASE | VASCULAR DISEASE/ |
| COLON | LIVER DISEASE | CIRCULATION |
| CATARACTS | MIGRAINE | VENERAL DISEASE |
| DEPRESSION | MULTIPLE SCLEROSIS | (HERPES, HPV, ETC.) |
| DIABETES | PNEUMONIA | VISION PROBLEMS |

Other significant illnesses not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any abnormal tests (blood, x-ray, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGERIES/HOSPITALIZATIONS:** Please indicate if you had any of the following surgeries and indicate the year the surgery occurred.

|  |  |  |
| --- | --- | --- |
| APPENDIX | CATARACT SURGERY | KIDNEY/ BLADDER |
| BREAST BIOPSY | COLON/RECTAL SURGERY | TONSILS |
| BREAST MASTECTOMY | D & C | TUBAL LIGATION |
| C-SECTION | GALLBLADDER | TUBES IN EARS |
| CARDIAC SURGERY | HYSTERECTOMY | VASECTOMY |

Please list any other significant surgeries (back, knee, hip, shoulder, thyroid, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ARE YOU CURRENTLY ON ANY MEDICATIONS? If YES, list medications and dosages below:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ALLERGIES TO MEDICATIONS:** Please describe your allergic reaction(s)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CONFIDENTIAL HEALTH HISTORY**

**IMMUNIZATIONS AND PREVENTION**: Please indicate if you had any of the following immunizations/test(s) and the last date of service.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| \_\_ Tetanus | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ TB Skin test | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ PAP Smear | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_ Influenza vaccine | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ Hearing Test | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ Mammogram | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_ Pneumonia vaccine | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ Eye Exam | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ Bone Density | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_ Colon Cancer | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ Cholesterol | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ PSA Test | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**FAMILY HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Living** | **Deceased** | **Age** | **Chronic Health Problems/Cause of Death** |
| **Father** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Mother** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Brothers (B) (# \_\_\_\_)** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Sisters (S) (# \_\_\_\_)** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_** |
| **B or S** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_** |
| **B or S** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_** |
| **Spouse** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_** |
| **Children (#\_\_\_\_)** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_** |

Have any relatives suffered from any of the following, if yes; please list the relatives that were/was affected:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | WHO? |  | | WHO? |
| \_\_ Bleeding problems | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ High Blood Pressure | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_Cancer, breast | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ Kidney Disease | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_ Cancer, colon | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ Liver Disease | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ Mental Illness | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_ Diabetes | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ Seizures | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_ Glaucoma | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ Stroke | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_ Heart Disease | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_Thyroid | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_ Other | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**SOCIAL AND PERSONAL HISTORY**

Answering these confidential questions honestly will allow an accurate assessment of your health risk(s). If you are uncomfortable with any question you have the option to leave it blank.

Current Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_ Single \_\_ Married (Year: \_\_\_) \_\_Widowed (Year: \_\_\_\_) \_\_ Separated (Year: \_\_\_) \_\_Divorced (Year: \_\_\_)

Married \_\_ time(s) 1st Marriage \_\_ year (s) \_\_\_number of children 2nd \_\_\_yrs \_\_\_children 3rd \_\_\_yrs \_\_\_children

I live with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Current tobacco use: Type: \_\_ Cigarette Cigar \_\_Pipe \_\_ Chew Amount/Day: \_\_\_ \_\_\_\_ Years: \_\_\_\_\_

\_\_ Former tobacco use: Type: \_\_ Cigarette Cigar \_\_Pipe \_\_ Chew Amount/day: \_\_\_\_\_\_\_\_ Years: \_\_\_\_\_ Quit Date: \_

\_\_ Exposure to second hand smoke

\_\_ Consume alcohol Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Much? \_\_\_\_\_\_\_\_\_\_ How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (per day/week)

\_\_ Use recreational drugs Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Much? \_\_\_\_\_\_\_\_\_\_ How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (per day/week)

\_\_ Consume caffeine Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Much? \_\_\_\_\_\_\_\_\_\_ How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (per day/week)

\_\_ Exercise regularly Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (per day/week)

\_\_ Use sunscreen \_\_Take calcium supplements Do you wear your seatbelt? \_\_\_\_\_\_\_\_

\_\_ Have you had a blood transfusions? Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have tattoos? \_\_\_\_\_\_

**Sexual History:**

Are you sexually active? \_\_Yes \_\_No \_\_Not currently

My sexual partner(s) is/are: \_\_male \_\_female was/were: \_\_male \_\_female

History of sexually transmitted diseases? \_\_ Yes \_\_No \_\_ Use contraception Type: \_\_\_\_\_\_\_\_\_\_\_

Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_