Chantilly Family Practice Center

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PERSONAL HABITS

Do you use tobacco?	❑ YES	❑ NO	If yes, how much? _____	How long? _____
Do you drink alcohol?	❑ YES	❑ NO	If yes, how much per week?	_____
Do you use drugs?	❑ YES	❑ NO	If yes, What kind(s)?	_____
Do you exercise?	❑ YES	❑ NO	If yes, How many hours per week?	_____
Have you lost / gained weight in past 6 months?	❑ YES	❑ NO	If yes, How many pounds?	_____
Have you had a Cholesterol test in past 5 years?	❑ YES	❑ NO	If yes, was the result elevated?	_____
Do you do breast / Testicular self exams?	❑ YES	❑ NO	Have you had a dental exam in the past year?	_____

FEMALES ONLY

Have you had any recent abnormal bleeding, discharge or itching?	❑ YES	❑ NO	Number of pregnancies: Number of children:	_____ _____
Have you had a thyroid function test?	❑ YES	❑ NO	Age periods began:	_____
Do you take a calcium supplement?	❑ YES	❑ NO	Days period last:	_____
Are your periods regular?	❑ YES	❑ NO	Date of last menstrual period:	_____
Have you ever had an abnormal Pap smear?	❑ YES	❑ NO	Date of last mammogram:	_____
Have you had any miscarriages?	❑ YES	❑ NO	Date of last pap smear:	_____
Have you had any abortions?	❑ YES	❑ NO	Method of birth control:	_____

Check if you have had any of the following conditions:

Endometriosis	❑ YES	❑ NO
Fibrocystic Disease	❑ YES	❑ NO
Pelvic Inflammatory Disease	❑ YES	❑ NO

_____ _____

Patient's signature Date