If you have completed sections 1-4 since your last birthday, please proceed to section 5. **Check all that apply.**

### 1. Medical History
- [ ] Anemia
- [ ] Anxiety
- [ ] Arthritis
- [ ] Asthma
- [ ] Bleeding Disorder
- [ ] Blood Clots/DVT
- [ ] Cancer
- [ ] CHF/Heart Failure
- [ ] Depression
- [ ] Diabetes
- [ ] Emphysema/COPD
- [ ] GERD/Heartburn/Acid Reflux
- [ ] Heart Disease
- [ ] HIV/AIDS
- [ ] Hypertension/High Blood Pressure
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Palpitations/Racing Heart
- [ ] Seizures
- [ ] Stroke
- [ ] Thyroid Problems
- [ ] Other ________________

### 2. Surgical History
- [ ] No surgery
- [ ] Anesthesia Complications
- [ ] Appendectomy
- [ ] Breast surgery
- [ ] Colonoscopy
- [ ] Coronary Artery Bypass
- [ ] Coronary Artery Stent
- [ ] Eye Surgery
- [ ] Gallbladder Surgery (Cholecystectomy)
- [ ] Hernia repair Location ______________
- [ ] Hysterectomy
- [ ] Joint Replacement
- [ ] Prostate Surgery
- [ ] Spine Surgery
- [ ] Organ Transplant
- [ ] Other ________________

### 3. Social History
- **Alcohol Use**
  - [ ] Yes
  - [ ] No
  - [ ] Never
- [ ] Wine
- [ ] Beer
- [ ] Liquor
- [ ] Drinks per Week _____________
- **Street Drug Use**
  - [ ] Yes
  - [ ] No
  - [ ] Never
- [ ] Marijuana
- [ ] Methamphetamines
- [ ] Cocaine
- [ ] Heroin
- [ ] Other
- **Tobacco Use**
  - [ ] Yes
  - [ ] No
  - [ ] Never
- [ ] Type _________________
- [ ] Current Smoker Packs per day _____
- [ ] Former Smoker Packs per day _____
- **Sexually Active**
  - [ ] Yes
  - [ ] No
  - [ ] Not Currently Partners
  - Check all that apply
    - [ ] Female
    - [ ] Male
  - **Birth Control / Protection**
    - [ ] Yes
    - [ ] No
    - Method ________________

### 4. Family Medical History
- [ ] I have no family history
- [ ] I have unknown family history

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<tr>
<th>Relationship</th>
<th>Anemia</th>
<th>Anxiety</th>
<th>Arthritis</th>
<th>Asthma</th>
<th>Bleeding Disorder</th>
<th>Blood Clots / DVT</th>
<th>Cancer</th>
<th>CHF/Heart Failure</th>
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If you have completed sections 1-4 since your last birthday, please proceed to section 5.

5. Primary Care Network

A. ALLERGIES

Allergies to Medications / Latex – Please Include Type of Reaction ____________________________________________________
____________________________________________________________________________________________________________

B. MEDICATIONS

Please list current medications. Include herbal and over the counter medications, dose and how many times a day you take the medication.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How many times do you take the med each day</th>
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C. HEALTH CARE LEARNING – This information will help us to provide you with medical information important to your health.

1. What is your preferred language for learning medical information?
   - [ ] English
   - [ ] Japanese
   - [ ] Vietnamese
   - [ ] Arabic
   - [ ] Spanish
   - [ ] Chinese
   - [ ] Russian
   - [ ] Hmong
   - [ ] American Sign Language
   - [x] Other (specify) _____________

2. How do you prefer to learn new medical information?
   - [ ] Listening
   - [ ] Reading
   - [ ] Demonstration
   - [ ] Pictures
   - [ ] Other (specify) _______________________

3. Do any of the following affect how you learn new information?
   - [ ] Difficulty Reading
   - [ ] Eyesight
   - [ ] Emotional Condition
   - [ ] Hearing
   - [ ] Physical Condition
   - [ ] Other _____________