Name: _____ DOB: _____

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9. Do you drink alcohol? ❍ YES ❍ NO
   If yes:
   a. Have you ever felt you should cut down on your drinking? ❍ YES ❍ NO
   b. Have people ever annoyed you by nagging you about your drinking? ❍ YES ❍ NO
   c. Have you ever felt guilty about your drinking? ❍ YES ❍ NO
   d. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ❍ YES ❍ NO

10. Prevention:
    a. Which of the following are included in your diet:

Grains and starches	❍ a lot	❍ some	❍ few
Vegetables	❍ a lot	❍ some	❍ few
Dairy foods	❍ a lot	❍ some	❍ few
Meats	❍ a lot	❍ some	❍ few
Sweets	❍ a lot	❍ some	❍ few

    b. Exercise:
       Activity _____
       Days per week _____
       Time/duration _____ minutes
       Exertion: ❍ stroll ❍ mild ❍ heavy
    c. Do you always wear seat belts? ❍ YES ❍ NO
    d. If over 30 years old, have you had your cholesterol level checked in the past five years? ❍ N/A ❍ YES ❍ NO
    e. Have you had a tetanus shot in the past 10 years? ❍ YES ❍ NO
    f. Does your house have a working smoke detector? ❍ YES ❍ NO
    g. Do you have firearms at home? ❍ YES ❍ NO
    h. Have you ever had a mammogram? ❍ YES ❍ NO
       If yes, date of last: _____ where: _____
       Have you ever had any abnormal mammograms? ❍ N/A ❍ YES ❍ NO
       If yes, date: _____ problem: _____
       For abnormality, did you have any of the following:

Biopsy	❍ YES	❍ NO
Cyst fluid drained	❍ YES	❍ NO
Surgery	❍ YES	❍ NO

    i. How many sexual partners have you had in the last 12 months? ____ In your lifetime? ____
    j. When is the last time you had a dental check-up?_____

11. Please describe any concerns you have:

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Thank you for your help.

Continued ➤