

VAIL VALLEY MEDICAL CENTER

Patient Epidemiological Information

Patient's Name: _____

Date of Birth: _____ M.D. you are seeing: _____

Social History:

Where were you born? _____

Where have you lived most of your life? _____

How long have you lived in Colorado? _____

What is your primary occupation? _____

Are you currently working? _____

If retired, what had your occupation been? _____

Did you ever work in an occupation that involved exposure to cancerous chemicals, fumes or to other carcinogens? Yes___ No___. If yes, how many years? ___

Habits

Have you ever smoked: Cigarettes _____ Number per day _____
Pipes _____ Number per day _____
Cigars _____ Number per day _____

How many years have you smoked? _____

Did your parents smoke? Mother _____ Father _____ How much? _____

Have you quit smoking? Yes _____ No _____ When? _____

Have you ever chewed tobacco? Yes _____ No _____ How much? _____

Have you quit chewing tobacco? Yes _____ No _____ When? _____

Do you drink alcoholic beverages? Yes _____ No _____ How often? _____

How much? _____ When did you start? _____

When did you quit? _____

On the average, how much coffee/tea do you drink?

Regular coffee _____ cups/day For how many years? _____

Decaf coffee _____ cups/day For how many years? _____

Regular tea _____ cups/day For how many years? _____

Decaf tea _____ cups/day For how many years? _____

Male Patients

Have you ever received hormone therapy? Yes _____ No _____

Medication Name: _____

Date received: _____

Please continue on second page...

Female Patients

Are you now, or is there a chance that you might be pregnant? Yes _____ No _____

Number of pregnancies? _____ Number of deliveries? _____

Did you breast feed any of your children? Yes _____ No _____

Did you ever take hormones (i.e. estrogen, birth control pills, androgens, etc.)? Yes _____ No _____

If yes, for how long? _____

Name of prescribing physician?

Are you currently having menstrual periods? Yes _____ No _____

Date of last menstrual period? _____

Family History**Father**

 If living, age

 If deceased, age at death

Medical Problems

Cause of death

Mother

 If living, age

 If deceased, age at death

Medical Problems

Cause of death

Brothers/Sisters

Name	If living, age	Medical Problems	Cause of death, age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Children

Name	If living, age	Medical Problems	Cause of death, age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Grandchildren

Yes _____ No _____ If yes, number of boys _____ Number of girls _____

Do they have medical problems? Yes _____ No _____ If yes, please describe:

