

## Prepare for your visit

This form will help you prepare for your upcoming visit with your doctor. You can complete it on your computer (Mac or PC) and e-mail it to your doctor ahead of time. Or, you may fill it out on the computer, print it, and bring it with you to your visit. Instructions for completing and saving this form vary depending on whether you use a Mac or a PC. To send us your feedback or questions about the form, please e-mail [helpwithforms@kp.org](mailto:helpwithforms@kp.org).

**Caution:** When using a public computer (library, Internet cafe, etc.), saving your entries may make it possible for others to view your information. To avoid this, never save your personal information on a public computer.

## How to fill out the form

**Step 1 PC users:** Use your mouse to position your cursor over the field you would like to complete. Click inside the field and when your cursor appears, type your response to each question using your keyboard.

**Mac users:** See **Step 2**.

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## Step 2 PC users:

**Please use your native browser (Internet Explorer):**

➡ **Click the Save button at the bottom of the form** to create a copy of your completed form as a PDF document on your computer. In the dialog box that opens, select the folder where you want to store this file and click "Save." Do not save the file under a new name.

**Remember where you save this file.** To print the form, select the **Print button** at the bottom of the form.

**Mac users:**

**Please use your native browser (Safari):**

➡ From the File menu select **Save as** to create a copy of your uncompleted form as a PDF document on your computer. In the dialog box that opens, select the folder where you want to store this file and click "Save." Do not save the file under a new name. **Remember where you save this file.**

➡ **To fill out the form**, open it with Acrobat Reader. Then, use your mouse to position your cursor over the field you would like to complete. Click inside the field and when your cursor appears, type your response to each question using your keyboard. Save your file under the same name.

➡ To print the form, select the **Print dialog box** from the File menu on Acrobat.

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## Step 3

**PC users**, when you are ready to send this form, click the **E-mail Form** button, which will launch your browser. Then log in to your [kp.org](http://kp.org) account. **Mac users**, please launch your browser and login to your [kp.org](http://kp.org) account.

➡ Once your login is successful, create a message to your doctor.

➡ Attach the completed form by clicking on **Browse** in the **Attach File** section below your message. In the dialog box that opens on your screen, locate the form you saved on your computer in Step 2. Click on the file name to select it and click Open. This will select the form to be attached to your message. Click **Send** to send the message to your doctor.

**DONE!** You can now close the browser.



Name

Today's Date

Medical Record No

Place of birth

Your Occupation

Marital Status

Your Partner's Occupation

If you have children, what are their ages?

Who lives with you or do you live alone?

What are your hobbies?

## PERSONAL MEDICAL HISTORY

Allergy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
COPD/Emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Atrial fibrillation	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Heart murmur as an adult	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Heart disease/heart attack	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Congestive heart failure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Rheumatic fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
High cholesterol	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
High blood pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
History of cancer or tumor	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Thyroid condition (hypo or hyper)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Osteoporosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Bone fractures	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Radiation treatments to the head/neck	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Glaucoma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Acid reflux or heartburn	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Hepatitis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Liver Cirrhosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Stomach or duodenal ulcer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Irritable bowel disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Colon or bowel disease (including polyps)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:

**PERSONAL MEDICAL HISTORY (continued)**

Kidney problem (including stones)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Gynecologic problems (including fibroids or endometriosis)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Prostate problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Migraine headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Seizures/Epilepsy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Arthritis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Rheumatoid Arthritis or Lupus	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Gout	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Anemia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Blood clots	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Blood transfusion before 1992	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
History of chicken pox	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Spleen removed	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
History of pneumonia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
History of positive skin test for tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Alcohol/drug problem	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Anxiety or panic attacks	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Depression	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Bipolar disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Vegetarian diet	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

**PERSONAL SURGICAL HISTORY**

Abdominal surgery	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Appendix removed	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Back surgery	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Biopsy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Breast surgery	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Coronary bypass	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Coronary stenting	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Gallbladder removal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:
Heart surgery (other than bypass/stents)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	COMMENT:



**FAMILY HISTORY** *(check all that apply)*

	NONE	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER
Healthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemochromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PREVENTATIVE CARE** *(indicate dates, please bring documentation with you to your visit)*

Pneumonia vaccine	Colonoscopy
Tetanus vaccine	Pap smear
Zoster or chickenpox vaccine	Mammogram
	Bone density scan

**OTHER HEALTH ISSUES**

Tobacco use	<input type="checkbox"/> Never	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
	▶ Current smoker?	<input type="checkbox"/> YES	Packs/day	# Years	
	▶ Former smoker?	<input type="checkbox"/> YES	# Years smoked	Quit Date	
	▶ Other tobacco, including pipes, cigars, snuff, or chews				
Alcohol use	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Type of drink	# of drinks /week	
Drug use	▶ Do you use marijuana or recreational drugs?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	▶ Have you ever used needles to inject drugs?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Sexual Activity	▶ Are you sexually active?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	▶ Do you have sex with:		<input type="checkbox"/> Men	<input type="checkbox"/> Women	<input type="checkbox"/> Both
	▶ Birth control method				
Do you have an Advance Directive for Health Care (ADHC)?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have a Durable Power of Attorney for medical decision-making?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have a Physician Order for Life Sustaining Therapy (POLST)?				<input type="checkbox"/> YES	<input type="checkbox"/> NO