**Owner’s Manual: A & P**

Profile Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race / Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Pressure (BP) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pulse : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Respiration Rate : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temperature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Type : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH ISSUES:**

**VISION**:

I wear: Glasses Contact Lenses Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NA

**DENTAL**:

I see a dentist: twice per year. once per year. whenever I have a problem.

I have --- braces. --- had braces.

I have ---- my wisdom teeth. --- had my wisdom teeth removed.

**EXERCISE** : Do you exercise regularly? Yes No

What kind of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How long (minutes) ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIET** :

How would you rate your diet? Good Fair Poor

Do you take supplements? Yes No If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies / Intolerance(s) (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**TOBACCO** Use: Smoke cigarettes: Never No Yes

Approximately how many years have you smoked? \_\_\_\_\_\_\_\_\_\_

Current smoker: Packs/day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other tobacco: Pipe Cigar Snuff Chew

**ALCOHOL** Use: Do you drink? No Yes

Number of drinks /week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Beer Wine Liquor

**DRUG** Use:

Do you use marijuana or recreational drugs? No Yes

Have you ever used needles to inject drugs? No Yes

**SEXUAL ACTIVITY** : Sexually involved currently: No Yes

Sexual partner(s) is / are have been male female.

Birth Control Method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**:

Describe any medical conditions/issues that you have or have had. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
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**MENTAL / EMOTIONAL** :

Do you feel anxiety? Yes No If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you ever feel suicidal? Yes No

Is anyone abusing or threatening you? Yes No

**IMMUNIZATIONS:**

Tetanus (Td) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ with Pertussis (Tdap) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ MMR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Varicella (Chicken Pox) shot or illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pneumovax (Pneumonia) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Influenza (flu shot) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zostavax (shingles) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ HPV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Meningitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_