

Houston Clinic For Lungevity
Follow Up Patient Form Houston Clinic For Lungevity

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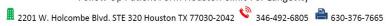
□Diabetes	
\Box CVA(stroke)	
☐ High blood pressure	
☐ Atrial Fib	
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Please provide your **FAMILY HISTORY**:

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	Mother	Father	Sister	Brother	Other
Cancer,Type					
Asthma					
Hypertension					
Mental Illness					
Heart Disease					
Diabetes					
Other					



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Please provide your **SOCIAL HISTORY**:

Do you smoke?
☐ yes ☐ no ☐ former
if yes, □ light □ moderate □ heavy
how often:
years smoked:
Year quit:
How many cigarettes a day?
How soon after you wake up do you smoke?
Have you ever tried to quit?
□yes □ no
Do you drink alcohol?
☐ yes ☐ no ☐ former
How often did you have a drink in the past year?
How many drinks did you have on a typical day in the past year?
How often did you have 6 or more drinks on one occasion in the past year?
Signature:
X
Date: