Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Personal / Family / Social History

Please answer every question.

STAFF: Handwritten responses must be entered **MANUALLY**.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PATIENT'S MEDICAL HISTORY

Please indicate if **THE PATIENT** has a history of the following:

- Anesthesia Problems
- Anxiety Disorder
- Arthritis / Joint Pain
- Asthma
- Autoimmune Disorders
- Blackout Spells
- Bleeding Problems
- Blood Thinner Treatment
- Depression
- Diabetes
- Enlarged Lymph Nodes
- Hearing Loss
- Heart Attack
- Heart Failure
- Heart Pain / Angina
- Hepatitis
- High Blood Pressure
- High Cholesterol
- Jaundice (as an infant / child)
- Kidney Disease
- Lung / Respiratory Disease
- Memory Loss
- Migraines
- Reflux / GERD
- Seizures / Convulsions
- Skin Disorders
- Stroke / CVA Of The Brain
- Thyroid Problems
- Cancer (please specify): _____
- Other Disease Or Significant Medical Illness (please specify): _____
- **NONE of the Above**

FAMILY MEDICAL HISTORY

Please indicate if **THE PATIENT'S FAMILY** has a history of the following:
(ONLY include parents, grandparents, siblings and children.)

- Allergies
- Anesthesia Problems
- Bleeding Problems
- Cancer
- Diabetes
- Hearing Loss
- Heart Disease
- High Blood Pressure
- Stroke
- Tuberculosis
- **Family History Unknown**
- **NONE of the Above**

PATIENT'S SOCIAL HISTORY

What is the patient's cigarette smoking status? Current (every day) ○ Previous ○ Current (some days) ○ Never ○

How many packs of cigarettes does the patient (or did the patient) **smoke daily?** <½ ○ ½ ○ 1 ○ 1 ½ ○ 2 ○ >2 ○

How many cigars / pipes does the patient (or did the patient) **smoke daily?** <½ ○ ½ ○ 1 ○ 1 ½ ○ 2 ○ >2 ○

Does the patient chew tobacco? Current (every day) ○ Previous ○ Current (some days) ○ Never ○

Is the patient exposed to passive (second hand) **smoke?** Yes ○ Yes, Outdoors Only ○ No ○

Does the patient use recreational drugs? Yes ○ No ○

Does the patient drink alcoholic beverages? Yes ○ No ○

If yes, how often? Socially, Having <1 Drink Per Day ○ Weekly ○ Rarely ○ Daily ○

Does the patient drink any of the following caffeinated beverages? (Mark all that apply.)

Coffee ○ Tea ○ Soft Drinks ○

If yes, how many per day? Occasionally ○ 0 ○ 1 - 2 ○ 3 - 4 ○ 5+ ○

Patient's marital status: Single ○ Partnered ○ Separated ○ Married ○ Divorced ○ Widowed ○