SOCIAL HISTORY

Do you drink caffinated beverages? ◯ Yes ◯ No

Cups/glasses per day? _____

Do you smoke? ◯ Yes ◯ No ◯ Past – How long ago? _____

Do you drink alcohol? ◯ Yes ◯ No Number per week _____

Has anyone ever told you to cut down on your drinking?

◯ Yes ◯ No

Do you use drugs for reasons that are not medical? ◯ Yes ◯ No
If yes, please list:

_____

Do you exercise regularly? ◯ Yes ◯ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ◯ Yes ◯ No

Do you wake up feeling rested? ◯ Yes ◯ No

PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if "yes")*

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High Blood Pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness (please list)

_____

Natural or Alternative Therapies (chiropracty, magnets, massage, over-the-counter preparations, etc.)

_____

Previous Operations

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ◯ No ◯ Yes Describe: _____

Any other serious injuries? ◯ No ◯ Yes Describe: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children:

_____

Do you know of any blood relative who has or had: (check and give relationship)

☐ Cancer _____	☐ Heart disease _____	☐ Rheumatic fever _____	☐ Tuberculosis _____
☐ Leukemia _____	☐ High blood pressure _____	☐ Epilepsy _____	☐ Diabetes _____
☐ Stroke _____	☐ Bleeding tendency _____	☐ Asthma _____	☐ Goiter _____
☐ Colitis _____	☐ Alcoholism _____	☐ Psoriasis _____	

Patient's Name _____ Date _____ Physician Initials _____