

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

<i>Type</i>	<i>Year</i>	<i>Reason</i>
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 _____	