SOCIAL HISTORY

Do you drink caffeinated beverages?

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 (chiropractic, 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