MEDICAL AND SOCIAL HISTORY

Name		Date of Birth		Today's Date	
Occupation		Employer			
Spouse's Name		# of Children		Years Education	

Past Surgical History

Surgery Type	Date	Surgery Type	Date

Family Medical History

	Self	Mother	Father	Sister	Brother	Other
Alcohol / Drug Abuse						
Seasonal Allergies						
Arthritis						
Asthma						
Bladder Problems						
Bleeding/Blood Disorder						
Cancer						
Depression						
Diabetes						
Eye Disease						
Genetic Diseases / Birth Defects						
Headaches / Migraines						
Heart Problems (attack / angina)						
High Cholesterol						
High Blood Pressure						
Kidney Disease						
Liver Disease/Hepatitis						
Mental Illness						
Musculoskeletal Disorders						
Nervous System Disorders						
Obesity						
Osteoporosis						
Sickle Cell Anemia						
Stroke						
Thyroid Disease						
Tuberculosis						
Psoriasis / Eczema						
Other: (describe)						
Other: (describe)						
Other: (describe)						

Substance Use

Drug Use	How Much	Type
☐ No		
☐ Yes		IV Drug Use
☐ Yes		Crack Cocaine
☐ Yes		Cocaine
☐ Yes		Ecstasy
☐ Yes		Heroin
☐ Yes		LSD
☐ Yes		Marijuana
☐ Yes		Methamphetamine
☐ Yes		Other: (describe)

Comment:

Family Status

Relationship	Alive	Deceased	Age at Death	Comments
Mother	☐	☐		
Father	☐	☐		
Sister	☐	☐		
Brother	☐	☐		
Daughter	☐	☐		
Son	☐	☐		
Other: (describe)	☐	☐		

Alcohol & Tobacco Use

Tobacco Use	How Much	Years	Date Quit	Types
☐ Never				
☐ Second Hand				
☐ Quit				
☐ Yes				☐ Cigarette ☐ Pipe ☐ Cigars ☐ Snuff ☐ Chew

Comment:

Alcohol Use	How Much	Type
☐ No		
☐ Quit		
☐ Yes		Bottles of beer
☐ Yes		Glasses of wine
☐ Yes		Shots / servings of hard liquor

Comment:

Personal Concerns

	No	Yes	Comments
Military Service	☐	☐	
Blood Transfusion	☐	☐	
Caffeine Concern	☐	☐	
Occupational Exposure	☐	☐	
Hobby Hazards	☐	☐	
Sleep Concern	☐	☐	
Stress Concern	☐	☐	
Weight Concern	☐	☐	
Special Diet	☐	☐	
Back Care	☐	☐	
Exercise	☐	☐	
Bike Helmet	☐	☐	
Seat Belt	☐	☐	
Self-exams	☐	☐	

Comment:

MEDICAL AND SOCIAL HISTORY Continued

Sexual History

Sexual Activity	Partners	Birth Control / Protection
☐ No		
☐ Not Currently		
☐ Yes	☐ Male ☐ Female	☐ Condom ☐ Pill ☐ Diaphragm ☐ IUD ☐ Surgical Type ☐ Spermicide ☐ Implant ☐ Rhythm ☐ Injection ☐ Sponge ☐ Cervical Cap ☐ Hormonal Patch ☐ IUS ☐ Vaginal Ring ☐ Withdrawal ☐ Other: (describe)

Comment:

Pregnancy History

☐ **Never Pregnant** ☐ **Currently Pregnant**

Number of Pregnancies:	Number of Live Births:	Number of Miscarriages:
Number of Elective/Therapeutic Abortions:	Number of Ectopic Pregnancies:	Number of Living Children:

YEAR YOU LAST HAD:			
	Date		Date
☐ Flu Vaccine		☐ Cholesterol Test	
☐ T.B. Test		☐ Eye Exam	
☐ Stool Blood Test		☐ Pap Test	
☐ Dental Exam		☐ Breast Exam	
☐ Colonoscopy		☐ Mammogram	
☐ Tetanus Shot		☐ Bone Density Test	
☐ Pneumonia Shot			

FOR WOMEN ONLY

Date of last menstrual period ______________________

Regular cycle: ☐ Yes ☐ No

Spotting: ☐ Yes ☐ No Pain: ☐ Yes ☐ No

Pre-menstrual dysphoric disorder ☐ Yes ☐ No
(mood swings, irritability, tension, bloating)

Are you Using birth control: ☐ Yes ☐ No

FOR MEN ONLY

	Date		Date
☐ PSA		☐ Prostate Exam	

Current Medications:

Allergies: