Patient Name: Date of birth: ____/____/_____

FAMILY HISTORY

Check if any of your BLOOD relatives have had any of the following:

DISEASE	RELATIONSHIP TO YOU
Asthma	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, stroke	
High Blood Pressure	
Kidney Disease	
Neurologic Condition	
Bleeding disorder	
Other, please list	

SOCIAL HISTORY

Educational Background

☐ None ☐ Home-Schooling ☐ Elementary School ☐ High School ☐ College Graduate
☐ GED ☐ Grad School ☐ Some College ☐ Trade School ☐ Technical School
☐ Post-College ☐ Medical School ☐ Law School

CHECK APPROPRIATE ANSWERS:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

How many children do you have? ____

Do you use tobacco? ☐ Current ☐ Former ☐ Never ☐ Unknown

Type: ____ Units/day: ____ Years used: ____ Pack Years: ____

Ever tried to quit? ☐ Yes ☐ No Year quit: ____ Longest tobacco free: ____

Relapse reason: ____ Passive smoke exposure? ☐ Yes ☐ No

Smoker Status (Meaningful Use)

☐ Current Every Day Smoker ☐ Smoker, Current Status Unknown ☐ Former Smoker
☐ Current Some Day Smoker ☐ Never Smoker ☐ Unknown if Ever Smoked

Do you drink alcohol? ☐ Yes ☐ No ☐ Former

How frequently do you drink alcohol?

☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Rarely ☐ Socially ☐ Never

Do you use recreational drugs? ☐ Yes ☐ No ☐ Former

☐ Never ☐ Rarely ☐ Occasionally ☐ Often

What: ____ How often: ____

Exercise?

☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ 2-3 Times/Week ☐ 3-4 Times/Week ☐ Daily