

Patient Name: _____

Date: _____

PATIENT MEDICAL HISTORY

Please list major medical, psychiatric, or surgical illnesses you have had.

Illness / Surgery	Date of onset	Hospital treated at	Treating Physician	Treatment	Response

FAMILY HISTORY

Blood Relative (example, mom, dad, brother, sister)	Health Status (example. Good, poor)	Age (if living)	Age (if deceased)	Cause of death	Illness	Treatment

SOCIAL HISTORY

Marital Status: _____

Number of Children: _____

Occupation: _____

Alcohol	<input type="checkbox"/> Never <input type="checkbox"/> Beer Amount per day/week _____ <input type="checkbox"/> Liquor Amount per day/week _____ <input type="checkbox"/> Wine Amount per day/week _____
Tobacco	<input type="checkbox"/> Never Packs Per day _____ Type: (example: cigarettes, cigars, chew) _____
Recreational Drugs	<input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Quit (how long) _____ Type _____