MEDICAL HISTORY

PATIENT'S NAME _____ **DATE OF BIRTH**_____

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily >Drinks/week (avg.) ___

Use of tobacco: ☐ Never ☐ Previously, quit_____ ☐ Current (pack/day) ____ >Start (age)____

Use of drugs: ☐ Never ☐ Current ☐ In the past > Type & Frequency_____

Excessive exposure at home/work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne particles ☐ Noise

Military experience/yrs. Of service: _____

PATIENT'S MEDICAL HISTORY

Have you ever had the following, please check "Yes" or "No"

Diabetes	☐ NO	☐ YES	Seizures	☐ NO	☐ YES
High blood press	☐ NO	☐ YES	Stroke	☐ NO	☐ YES
Heart disease	☐ NO	☐ YES	Bleeding tendency	☐ NO	☐ YES
Arthritis	☐ NO	☐ YES	Veneral disease (VD)	☐ NO	☐ YES
Cancer	☐ NO	☐ YES	Hereditary defects	☐ NO	☐ YES

Explain any "YES" answers:

_____

_____

Previous Hospitalizations/Surgeries/Serious Illness: **Year**

_____ _____

_____ _____

_____ _____

Allergies to medications (list allergies & type of allergic reaction):

_____

_____

Date of last Tetanus _____ **Date of last Pneumovax** _____

FAMILY MEDICAL HISTORY

	AGE	DISEASES	IF DECEASED, Cause/Age at death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Other relatives not listed above:

_____	_____	_____
_____	_____	_____

_____ **DATE**_____

Signature of Patient (or guardian)