



Health History

Name: _____ Date of Birth: _____ Date: _____

Social History

Occupation _____
 Marital Status; M S W D (please circle)
 Use of Tobacco Never Previous but quit Current # packs per day: _____
 Use of Alcohol Never Rarely Moderate Daily Type & Frequency: _____
 Use of Marijuana Never Previous but quit Current Medical or Recreational? _____
 Street Drug Use Never Name of Drug: Last used: _____

Family History (list major family medical history) Non Contributory
 Father: _____ Living/Deceased
 Mother: _____ Living/Deceased
 Siblings: _____ Living/Deceased
 Other: _____ Living/Deceased

Do you have or have you had any of the medical Problems listed Below (please circle yes or no)

<i>Angina/Chest pain</i> Y/N	<i>Edema/Swelling</i> Y/N	MRSA (Resistant bacterial infecti Y/N
<i>Asthma</i> Y/N	<i>Emphysema</i> Y/N	<i>Neurological Problems</i> Y/N
<i>Arthritis</i> Y/N	<i>Fibromyalgia</i> Y/N	Type: _____
<i>Anemia</i> Y/N	<i>Gout</i> Y/N	<i>Osteoporosis</i> Y/N
<i>Alcohol abuse</i> Y/N	<i>Glaucoma</i> Y/N	<i>Problems w/ Surgery</i> Y/N
<i>Bowel Problems</i> Y/N	<i>Heartburn</i> Y/N	<i>Pulmonary Embolism</i> Y/N
Type: _____	<i>Heart Attack</i> Y/N	<i>Respiratory Issues</i> Y/N
<i>Bleeding disorders</i> Y/N	Date: _____	Type: _____
Type: _____	<i>High Blood Pressure</i> Y/N	<i>Seasonal Allergies</i> Y/N
<i>Bladder Problems</i> Y/N	<i>High Cholesterol</i> Y/N	<i>Skin Disorders</i> Y/N
Type: _____	<i>Heart Valve Disorde</i> Y/N	Type: _____
<i>Blood Clots</i> Y/N	<i>Hepatitis</i> Y/N	<i>Seizure disorders</i> Y/N
<i>Cancer</i> Y/N	Type: _____	<i>Sleep Apnea</i> Y/N
Type: _____	<i>Immune Disorder</i> Y/N	<i>Stroke</i> Y/N
<i>Cataracts</i> Y/N	Type: _____	Date: _____
<i>Diabetic</i> Y/N	<i>Kidney Problems</i> Y/N	<i>Thyroid</i> Y/N
Type: _____	<i>Liver Disease</i> Y/N	<i>Weight Loss</i> Y/N
<i>Depression</i> Y/N	<i>Lung Disease</i> Y/N	<i>Weight Gain</i> Y/N
<i>Drug Abuse</i> Y/N	<i>Mental Illness</i> Y/N	<i>Other:</i> _____

Allergies: (please list all allerg None **Allergy to Latex?** Y / N **Allergy to Metal?** Y / N

Surgeries: (please list all surgeries and the date) None

Please list medications and vitamins on back side

Jan-17