

Patient Name _____ Birth Date _____

PAST SURGICAL HISTORY

NO PAST SURGERIES

Year	Surgery / Hospitalization	Complications (If Any)

FAMILY HISTORY

Family Member	Age	Health Status/Major Illnesses	If Deceased, Cause Of Death	Age At Death
Father				
Mother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

SOCIAL HISTORY

Do You Have Children? No Yes - How Many? _____

Do You Live Alone? No Yes

Exercise? Daily Weekly Monthly Rarely Never What Type Of Exercise? _____

History Of Substance Abuse? No Yes - How Long? _____ How Much? _____ Type? _____

Do You Smoke? No Yes How Many Packs Per Day? _____ For How Many Years? _____

Did You Smoke In The Past? No Yes When? _____ Packs Per Day? _____ How Many Years? _____

Do You Drink Alcohol? Never 1-2 Times Per Year 1-2 Times Per Month 1-2 Times Per Week

Patient Signature _____ Date _____

Reviewed By: _____ Date _____