

Medical/Social History

Name: _____ DOB _____ Age _____ Today's Date _____

Occupation: _____ Marital Status _____

FAMILY HISTORY	DO YOU HAVE OR HAVE YOU EVER HAD:		
Father Mother Father's Parents Mother's Parents Siblings	Current	Past	Never
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Stroke	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Mental Illness	_____	_____	_____
Depression	_____	_____	_____
		AIDS/HIV	_____
		Depression	_____
		High Blood Pressure	_____
		Stroke	_____
		Cancer	_____
		Diabetes	_____
		Epilepsy/Convulsions	_____
		Lung Problems (asthma/emphysema)	_____
		Ulcers	_____
		Rheumatic Fever	_____
		Headaches	_____
		Heart Disease	_____
		Hepatitis	_____
		Treated for Drug Abuse:	_____
		Other (please list) _____	_____

HOSPITALIZATION OR SURGERY

<u>Reason</u>	<u>Date</u>	<u>Reason</u>	<u>Date</u>

ALLERGIES (including any medications)

CURRENT MEDICATIONS

Allergic to Latex? **Tape?**

HABITS

Do you smoke now? Yes No
 How much _____

Have you ever smoked? Yes No
 How much _____

Do you use alcohol? Yes No
 How much _____

Do you drink coffee? Yes No
 How much _____

Do you use caffeine? Yes No
 How much _____

Do you use illicit drugs: Yes No
 What/How much _____

DEPRESSION

Have you ever been treated for depression?:

Dates: _____

Physician: _____

Medications: _____

Hospitalization: _____