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| **Social history** |
|  **Tobacco Use** [ ]  Never [ ]   Current [ ]  Prior use [ ]  2nd hand  Type: Freq: # of years: Quit date (if applicable): |
|  **Alcohol Use** [ ]  Never [ ]  Current [ ]  Prior use (describe): **If responded current above, please answer how many drinks PER WEEK** [ ]  1-3 drinks [ ]  4-6 drinks. [ ]  7-13 drinks [ ]  14 or more |
|  **Marijuana Use** [ ]  Never [ ]  Occasional [ ]  Daily  |
|  **Street Drug Use** [ ]  Never [ ]   Current Type: Freq: [ ]  Prior use Quit date: |
|  **Diet notes:** |  |
| **Occupation** Currently Employed [ ]  Yes [ ]  No | **Exercise type/frequency** |  |
|  **Personal and Family Medical history**  |  |  |
|  | Self | Father | Mother | Siblings | Sons | Daughters | Other relative |
|  Deceased?  (Cause/age) |  |  |  |  |  |  |  |
|  Hypertension |  |  |  |  |  |  |  |
|  Heart Disease |  |  |  |  |  |  |  |
|  Stroke |  |  |  |  |  |  |  |
|  Diabetes (Type 1 or 2) |  |  |  |  |  |  |  |
|  Kidney Disease |  |  |  |  |  |  |  |
|  Cancer (type) |  |  |  |  |  |  |  |
|  Liver Disease |  |  |  |  |  |  |  |
|  Depression / Anxiety  |  |  |  |  |  |  |  |
|  Obesity |  |  |  |  |  |  |  |
|  Other - Describe |  |  |  |  |  |  |  |

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| **Allergy list (Medication or environmental)** | **Type of reaction** |
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| **Hospitalizations and Surgeries. Please list facility and description** | **Date** |
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| **Medication list, include supplements and over the counter drugs – Attach list as needed** |
| **Medications** | **Dose and Frequency** | **Reason for use** | **Date started** |
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| **Other physicians and providers of care**  |  |
| **Name**  | **Specialty/provider type** | **Reason** |
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**Patient/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**