

PAST MEDICAL HISTORY

SURGERIES/HOSPITALIZATIONS	YEAR	COMPLICATIONS

Have you ever had general anesthesia? NO _____ YES _____

If yes, did you have any problems? NO _____ YES _____ Describe: _____

FAMILY HISTORY

FAMILY MEMBER	ALIVE	DECEASED	AGE	HEALTH STATUS/CAUSE OF DEATH
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

SOCIAL HISTORY

Work in the home: _____ Employed (occupation): _____ Student: _____

Single: _____ Married: _____ Divorced: _____ Separated: _____ Widowed: _____

Children: No: _____ Yes: _____ Number of children: _____

Do you live alone? No: _____ Yes: _____

Do you exercise: Daily: _____ Weekly: _____ Monthly: _____ Rarely: _____ Never: _____

What type of exercises? _____

Are you on a special diet? No: _____ Yes: _____ Describe: _____

History of substance abuse? No: _____ Yes: _____ Describe: _____

Smoke currently? No: _____ Yes: _____ packs per day for _____ years.

Quit smoking? This year: _____ >1 year: _____ >5 years _____ >10 years _____

Previously smoked: _____ packs per day for _____ years.

Drink alcohol? Daily: _____ 1-2 x/week: _____ 1-2 x/month: _____ 1-2 x/year: _____

Reviewed by: _____, D.O. Date: _____