

Today's Date _____ Patient Name _____ DOB _____

Hospitalization & Surgical History - List all hospital admissions and operations you have had.

Reason for Hospitalization/Surgery	Year
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____
7 _____	_____
8 _____	_____
9 _____	_____
10 _____	_____

Yes No Did you have any problems with anesthesia? If yes, please describe.

Social History

Yes No Do you currently smoke or use other tobacco products? If yes, how many per day? _____

Yes No Have you smoked or used other tobacco products in the past? If yes, how many per day? _____
How many years since you last smoked? _____

Yes No Do you drink caffeinated beverages? If yes, what type, how often, how much? _____

Yes No Do you drink alcohol? If yes, what type, how often, how much? _____

Yes No Do you exercise regularly? If yes, what type? _____
How often and how long? _____

Family Medical History - Check the box next to any medical condition below that has affected any of your immediate family members (parents, brothers, sisters), state your relationship and their age at onset.

	Relationship	Age at onset
<input type="checkbox"/> High Blood Pressure	_____	_____
<input type="checkbox"/> High Cholesterol	_____	_____
<input type="checkbox"/> Heart Disease	_____	_____
<input type="checkbox"/> Stroke	_____	_____
<input type="checkbox"/> Migraines	_____	_____
<input type="checkbox"/> Seizures/Convulsions	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Bleeding/Blood-clotting Disorder	_____	_____
<input type="checkbox"/> Allergies	_____	_____
<input type="checkbox"/> Asthma	_____	_____
<input type="checkbox"/> Thyroid Problems	_____	_____
<input type="checkbox"/> Osteoporosis	_____	_____
<input type="checkbox"/> Psychiatric Disorder/Mental Illness	_____	_____
<input type="checkbox"/> Alzheimer's/Dementia	_____	_____
<input type="checkbox"/> Cancer - type:	_____	_____
<input type="checkbox"/> Other:	_____	_____