Social History

Marital Status: S M W D Number of Children: ______
Occupation: ______ Previous Occupation: ______

Tobacco Use: ☐ Yes ☐NO Type of Tobacco: ______

How long has it been since you last smoked: ______
Are you a: ☐ Current Smoker ☐ Former Smoker Are you interested in quitting? ☐ Yes ☐NO
When did you start smoking: ______ How soon after you wake up do you smoke your first cigarette: ______
How long was your usage? ______ When did you stop smoking? ______
How many cigarettes a day do you smoke? ______

Alcohol Screening: Alcohol use: ☐Yes ☐ No How many drinks in an average week? ______
How often did you have a drink containing alcohol in the past year? ______
How many drinks did you have on a typical day when you were drinking in the past year? ______
How often did you have six or more drinks on one occasion in the past year? ______

Family History: (Check all illnesses which have occurred in any blood relatives/write relationship to you)
☐Cancer ☐Diabetes ☐Liver Disease ☐Heart Disease ☐Stroke ☐Kidney Disease ☐Bleeding tendency
☐Mental illness ☐Alcoholism ☐High Blood Pressure ☐Other: ______

Which relative has or had any of the checked illnesses? ______

Is this relative alive or deceased: ☐Alive ☐ Deceased
Medications: (List all prescription drugs you are taking, along with dosage and schedule)

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______

If no medications please check: ☐
List all non-prescription drugs/aspirin/ibuprofen: ______

Allergies: (List all allergies to drugs or foods) If no allergies please check:

1. ______
2. ______
3. ______
4. ______

In case of emergency contact:
Relationship: ______ Phone Number: ______

Signature of person completing this form: ______ Relationship to patient: ______

Doctor's signature: ______ Date: ______