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Name: \_\_\_\_\_

**Past Surgeries & Dates:**


**Social History**

Alcohol	Never	Social	Frequent	Type?	Quit?/When?
Drug use	Never	Occasional	Frequent	Type?	Quit?/When?
Exercise	Never	Occasional	Moderate	Heavy	
Tobacco	Never	Packs/Day		Smokeless	Quit/When?
Military	Active	Inactive	None		
Marital Status	Single	Married	Divorced	Widowed	

**Immediate Family Medical History (circle all that apply)**

High Blood Pressure	Yes	No	HIV/AIDS	Yes	No
Respiratory Problems	Yes	No	Heart Trouble	Yes	No
Bleeding Problems	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	Other Problems:	_____	
Stroke	Yes	No			

**Patient Medical History (circle all that apply)**

Abdominal Problems	Yes	No	Hepatitis	Yes	No
Anesthesia Problems	Yes	No	Hormone Abnormalities	Yes	No
Asthma	Yes	No	Hypertension	Yes	No
Bleeding Problems	Yes	No	Kidney Stones/Disease	Yes	No
Blood Clots	Yes	No	Lung Disease	Yes	No
Bowel Problems	Yes	No	Muscle Disease	Yes	No
Breast Lumps/Pain	Yes	No	Neurologic Disease	Yes	No
Bronchitis	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Wound Healing Issues	Yes	No
Cataracts	Yes	No	Diabetic	Yes	No
Convulsions/Seizures	Yes	No	Other:	_____	
Coronary Artery Disease	Yes	No			
Gerd	Yes	No			
Heart Disease	Yes	No			