Patient Name: ______________________________ Date: _________________

PATIENT MEDICAL HISTORY

Please list major medical, psychiatric, or surgical illnesses you have had.

Illness / Surgery	Date of onset	Hospital treated at	Treating Physician	Treatment	Response

FAMILY HISTORY

Blood Relative **(example, mom, dad, brother, sister)**	Health Status **(example. Good, poor)**	Age **(if living)**	Age **(if deceased)**	Cause of death	Illness	Treatment

SOCIAL HISTORY

Marital Status: _______________________ Number of Children: ____________

Occupation: _________________________

Alcohol	☐ Never ☐Beer Amount per day/week______________________________ ☐ Liquor Amount per day/week ___________________________ ☐ Wine Amount per day/week ____________________________
Tobacco	☐ Never Packs Per day ______ Type: (example: cigarettes, cigars, chew) __________________________
Recreational Drugs	☐ Never Type _______________________ ☐ Current ☐Quit (how long) ________________