First Name:_____ Last Name:_____ M.I. ____ Age ____DOB_____

Social History

Education: How many years of school have you completed? _____

Occupation: Your current employment status: ❑Retired ❑Unemployed ❑Homemaker ❑Employed – current occupation(s): _____

Previous Occupations/Jobs: _____

Disability: Are you disabled? ❑No ❑Yes → _____

Have you used any of the following substances?

Substance	Currently Use?	Previously Used?	Type/Amount/Frequency	How Long? (Years)	If Stopped, when? (Year)
Caffeine: coffee, tea, soda	❑No ❑Yes	❑No ❑Yes			
Tobacco	❑No ❑Yes	❑No ❑Yes			
Alcohol – beer, wine, liquor	❑No ❑Yes	❑No ❑Yes			
Recreational/Street drugs	❑No ❑Yes	❑No ❑Yes			

Please answer if patient is under the age of 18

Does anyone in the household smoke? ❑No ❑Yes

Does the child go to daycare or pre-school? ❑No ❑Yes If yes, number of days per week _____.

School age children: current grade _____.

Parental involvement: Mother and Father involved? ❑No ❑Yes

If joint custody: Primarily lives with ❑Mother ❑Father ❑Other _____

Surgery: List type and approximate year of surgery.

Type	Year

Do you have parts of your medical history that you only wish to discuss with the doctor? ❑No ❑Yes

Do you have any other medical problems not covered on this form. Please explain.

_____

Family History

Illness/Condition	Family Members: Father	Mother	Brothers	Sisters	Sons	Daughters	None	Describe
Cancer (describe the type of cancer for each person)								
Heart Disease								
Diabetes								
Stroke/TIA								
High Blood Pressure								
High Cholesterol or Triglycerides								
Liver Disease								
Alcohol or Drug Abuse								
Anxiety, Depression or Psychiatric Illness								
Tuberculosis								
Anesthesia Complications								
Genetic Disorder								
Hearing Loss								
Sleep Apnea								
Bleeding Disorders								
Allergies								

_____ _____

Signature of Patient, Guardian or Parent Date