MEDICAL/SOCIAL HISTORY FORM

Patient Name:_____ **Date of Birth**:_____

Please complete the following form to the best of your knowledge. If you are a returning patient you will be asked to complete this form once every **six months** to keep our records current.

MEDICAL HISTORY

1. Please check if you have ever had any of the following:

- ☐ Alzheimer's disease
- ☐ Arthritis
  Type:_____
- ☐ Blood disorders
- ☐ Broken bones/fractures
- ☐ Cancer
  Type: _____
- ☐ Chemical dependency
- ☐ Circulation problems
- ☐ Depression
- ☐ Diabetes/High blood sugar
  - ☐ Type I Diabetes
  - ☐ Type II Diabetes
- ☐ Head Injury
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Low blood sugar
- ☐ Kidney problems
- ☐ Latex allergy
- ☐ Lung problems
  Type: _____
- ☐ Multiple sclerosis
- ☐ Osteoporosis/Osteopenia
- ☐ Parkinson's disease
- ☐ Repeated infections
- ☐ Stroke
- ☐ Seizures/epilepsy
- ☐ Skin diseases
  Type: _____
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers/stomach problems
- ☐ Other:_____

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2. Have you recently had any of the following symptoms?

- ☐ Bowel/bladder problems
- ☐ Chest pain
- ☐ Coordination problems
- ☐ Difficulty swallowing
- ☐ Dizzy/Lightheadedness
- ☐ Fatigue
- ☐ Fever/chills/sweats
- ☐ Loss of appetite
- ☐ Loss of balance
- ☐ Nausea/vomiting
- ☐ Pain at night
- ☐ Shortness of breath
- ☐ Unexplained weakness
- ☐ Unexplained weight change

3. In the past month have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

4. During the past month have you lost interest or pleasure in doing things you used to enjoy? ☐ Yes ☐ No

5. Are you currently pregnant or think you might be pregnant?
☐ Yes ☐ No

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CLINICAL TESTS

1. Within the past year, have you had any of the following tests? (Check all that apply.)

- ☐ Angiogram
- ☐ Biopsy
- ☐ Bone Density Scan
- ☐ CT Scan
- ☐ Doppler Ultrasound
- ☐ Echocardiogram
- ☐ EKG (electrocardiogram)
- ☐ EMG (electromyogram)
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ Nerve Conduction Test
- ☐ Pulmonary Function Test
- ☐ Stress Test
- ☐ X-rays
- ☐ Other:_____

MEDICATION

1.. Please list any prescription medications you are currently taking and their dosages. (a separate list may be provided)

MEDICATION NAME	DOSAGE	REASON FOR TAKING

2. Please indicate if you are taking any of the following over the counter medications:

- ☐ Aspirin
- ☐ Tylenol
- ☐ Advil/Motrin/Ibuprofen
- ☐ Antacid
- ☐ Laxatives
- ☐ Vitamins/Mineral Supplements
- ☐ Decongestants
- ☐ Antihistamines
- ☐ Other:_____

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SURGERY / HOSPITALIZATIONS

1. Have you ever had surgery? ☐ Yes ☐ No

2. Please list approximate dates and reasons for any surgery or other conditions (including childbirth) that required hospitalization: *(a separate list may be provided)*

Date	Reason for hospital stay
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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SOCIAL HISTORY

Work Status

1. Employment / Work (Job / School / Play)
   ☐ Working full-time ☐ Working part-time
   ☐ Regular duty ☐ Light duty

2. Occupation: _____

   ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled

Cultural / Religious

1. Are there any customs or religious beliefs or wishes that might affect your care? ☐ No ☐ Yes

   a. Please explain:_____

Social/Health Habits

1. Smoking
   a. Do you currently use tobacco products? ☐ Yes ☐ No
      If yes: ☐ Cigarettes ☐ Cigars/Pipes ☐ Smokeless
      How many packs/day:_____
      If no: Have you used tobacco in the past? ☐ Yes ☐ No
      Year Quit:_____

2. Alcohol
   a. How many days per week do you drink beer, wine or other alcoholic beverages? _____

   b. If 1 beer, 1 glass of wine or 1 cocktail equals 1 drink, how many drinks do you have in average week? _____

3. Caffeine
   a. How much caffeinated coffee or caffeine containing beverages do you drink per day?_____

4. Exercise
   a. Do you exercise regularly?
      ☐ Yes Type: _____
      ☐ No
   b. On average, how many days per week do you exercise? _____
   c. For how many minutes, on an average day? _____

5. General Health Status. Please rate your health:
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Living Environment

1. With whom do you live?
   ☐ Alone ☐ Spouse only
   ☐ Spouse and others ☐ Child (not spouse)
   ☐ Other relative(s) ☐ Group Setting
   ☐ Personal Care Attendant
   ☐ Other:_____

Other

1. Primary Language:
   ☐ English ☐ Other:_____
   Do you need an interpreter ☐ Yes ☐ No

2. Learning Barriers
   ☐ None ☐ Vision
   ☐ Hearing ☐ Unable to read
   ☐ Unable to understand what is read
   ☐ Other _____

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Patient/Guardian Signature:_____ Date:_____

Reviewed by:_____ License #:_____ Date: _____