Name:_____ DOB:_____ Age_____

SOCIAL HISTORY

Marital Status: ____ Single _____ Married _____ Divorced _____ Widowed

Do you havy any children? ____ Yes _____No Ages:_____

Tobacco Use: ____ Yes _____No ____ Cigarettes _____ Chewing Tobacco _____Pipe_____ Nicotine Patches_____

Packs/Cigars/Pipes per Day:_____ Number of years:_____

Stopped Tobacco use

Alcohol: ____ No ____ Occasionally _____ Daily Type: Beer _____ Liquor_____ Wine_____ Drinks Per Day_____

Exercise: _____ Daily _____ Weekly _____Monthly _____Rarely _____Never Type of Exercise/Duration:_____

Occupation: _____

When was your last Tetanus vaccine? (mm/dd/yyyy) _____

Family History

Please Circle Living or Deceased	Father Age_____ Living Deceased	Mother Age_____ Living Deceased	Maternal Grandmother Age___ Living Deceased	Maternal Grandfather Age___ Living Deceased	Paternal Grandmother Age___ Living Deceased	Paternal Grandfather Age___ Living Deceased	Brother/Sister Ages:____ Living Deceased	Children Ages____ _____ Living Deceased
Heart Disease								
Hypertension								
Stroke								
Cancer,Type								
Diabetes								
Epilepsy								
High Cholesterol								
Glaucoma								
Anemia								
Thyroid Disease								
Bleeding Disorder								
AIDS								
Asthma								
Mental Illness								
Kidney Disease								