

Patient's name: _____

Birthdate: _____

Other Physicians: (attach separate piece of paper if necessary)

1. Name: _____ Telephone number: _____

Specialty: _____ Fax number: _____

2. Name: _____ Telephone number: _____

Specialty: _____ Fax number: _____

3. Name: _____ Telephone number: _____

Specialty: _____ Fax number: _____

Name of Pharmacy: _____ Telephone Number: _____

Address: _____ Fax Number: _____

Social History		Nutritional/Exercise Assessment
<p><i>Tobacco</i></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes _____ppd x _____years</p>	<p><i>Marital Status</i></p> <p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Civil Union</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Widow(er)</p>	<p><i>Typical Breakfast</i></p> <p>_____</p>
<p><i>Alcohol</i></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes _____Quantity _____ Frequency</p>	<p><i>Children</i></p> <p><input type="checkbox"/> Boy(s) Age(s) _____</p> <p><input type="checkbox"/> Girl(s) Age(s) _____</p>	<p><i>Typical Lunch</i></p> <p>_____</p>
<p><i>Illicit Drug Use</i></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes _____Quantity _____ Frequency</p>		<p><i>Typical Dinner</i></p> <p>_____</p>
<p><i>Advance Directive</i></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>		<p><i>Usual Snacks/Beverages</i></p> <p>_____</p>
		<p><i>Type of Exercise:</i></p> <p>_____</p>

Family History — list important medical problems of your parents:

Mother: _____

Father: _____

Any other special medical information: _____

<p>Family History</p> <p><i>Mother</i></p> <p><input type="checkbox"/> Alive, Age ____</p> <p><input type="checkbox"/> Deceased, Age ____ of _____</p> <p><i>Sister(s)</i></p> <p><input type="checkbox"/> Alive, Age ____</p> <p><input type="checkbox"/> Deceased, Age ____ of _____</p> <p><input type="checkbox"/> Alive, Age ____</p> <p><input type="checkbox"/> Deceased, Age ____ of _____</p> <p><input type="checkbox"/> Others</p>	<p>Notes _____</p> <p><i>Father</i></p> <p><input type="checkbox"/> Alive, Age ____</p> <p><input type="checkbox"/> Deceased, Age ____ of _____</p> <p><i>Brother(s)</i></p> <p><input type="checkbox"/> Alive, Age ____</p> <p><input type="checkbox"/> Deceased, Age ____ of _____</p> <p><input type="checkbox"/> Alive, Age ____</p> <p><input type="checkbox"/> Deceased, Age ____ of _____</p> <p><input type="checkbox"/> Others</p>
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Drug sensitivity and allergies (describe): _____

Have you ever been told you had one of the following?

- | | | | | | |
|--|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|
| Lung disorder | <input type="checkbox"/> yes | <input type="checkbox"/> no | Disease of the kidney | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| High blood pressure | <input type="checkbox"/> yes | <input type="checkbox"/> no | Diabetes | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Heart trouble | <input type="checkbox"/> yes | <input type="checkbox"/> no | Arthritis | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Nervous disorder | <input type="checkbox"/> yes | <input type="checkbox"/> no | Hepatitis | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Disease or disorder of the digestive tract | <input type="checkbox"/> yes | <input type="checkbox"/> no | Malaria | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Any form of cancer | <input type="checkbox"/> yes | <input type="checkbox"/> no | | | |

If answered yes to any of the above, please describe: _____

Disease or disorder of the blood? (describe) _____

Any physical defect or deformity? (describe) _____

Any vision or hearing disorders? (describe) _____

Any life-threatening conditions? (describe) _____

Have you been treated by a physician or been disabled or hospitalized during the last year? (describe)

Have you had or been advised to have a surgical operation within the last five years? (describe)

Signature _____ Date _____