

Past, Family and Social History

Do you take aspirin or any aspirin-containing drugs [Yes] [No]

List **all** medications, drugs or pills that you have taken in the last ten (10) days, including over the counter and vitamins

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

List all medicines you are allergic to or cannot take

1. _____
2. _____
3. _____

List all previous operations or surgeries

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

List previous serious illnesses and injuries. Also list ongoing medical problems for which you see a physician.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Women

Number of Pregnancies _____
Number of Children _____

Family History:

Family History of: (Check all that apply):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Muscular Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Endocrine Disease | <input type="checkbox"/> Colon Cancer |
| <input type="checkbox"/> Diabetes | | | |

Details: _____

Other Family History: _____

Social History:

Marital Status: Single__ Married__ Divorced__ Widowed__

Occupation: _____

Use of tobacco: Non Smoker__ Current packs/day__ Years of use__ Quit Date__

Use of alcohol: Non Drinker__ Type__ Ounces/Day__ Years of use__ Quit Date__

DO YOU HAVE A LIVING WILL? [] YES [] NO

NAME _____ TODAY'S DATE _____

DOCTOR _____ TODAY'S DATE _____

Office Use
Physician Initials