

Allergies: Please list Allergies and reactions.

Medicine

Reaction

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Medical Problems

Father _____

Mother _____

Brother _____

Sister _____

Any other Family History not mentioned: _____

Social History:

Occupation: _____

Level of Education: Grade School High School College/Vocational PhD/Other

With whom do you live with? _____

Are you: Single Married Divorced Widowed Living with Significant Other

Do you smoke?.....No Yes If yes, how much? _____ How long? _____

Have you ever been a cigarette smoker?.....No Yes If yes, when did you stop? _____

Do you drink alcohol?.....No Yes If Yes, how much? _____ How long? _____

Do you use recreational drugs?.....No Yes

Provider Signature

Date Reviewed