PERSONAL HISTORY

NAME: First Name Middle Initial Last Name

AGE:

◯ Right-handed
◯ Left-handed
◯ Ambidextrous

ALLERGIES (medications):

SOCIAL HISTORY

Do you smoke? ◯ Yes ◯ No ◯ Stopped
How many packs a day?
When did you stop smoking?

Do you drink alcohol? ◯ Yes ◯ No ◯ Stopped
How often do you drink?
When did you stop drinking?

Are you married? ◯ Yes ◯ No ◯ Divorced ◯ Single ◯ Seperated

Do you have children? ◯ Yes ◯ No

Occupation:

Education: ◯ High School ◯ Some college ◯ College graduate

Do you feel depressed? ◯ Yes ◯ No
Do you feel rested after sleep? ◯ Yes ◯ No
Do you awaken frequently at night? ◯ Yes ◯ No
How is your appetite? ◯ Good ◯ Fair ◯ Poor
Have you gained or lost weight? ◯ Same ◯ Lost ◯ Gained

MEDICATIONS
including over the counter and herbal medicines

Medicine	Dose	Reason taken		How many times daily

MEDICAL HISTORY

Please check any medical conditions present in your family and yourself.
Please provide pertinent details

Family	Patient	Condition	Family	Patient	Condition
☐	☐	Irregular heartbeat	☐	☐	Kidney problems
☐	☐	Coronary Artery Disease	☐	☐	GI problems
☐	☐	Stroke/TIA	☐	☐	Bleeding problems
☐	☐	Heart Attack	☐	☐	COPD/Asthma
☐	☐	Diabetes	☐	☐	Seizures
☐	☐	Thyroid problems	☐	☐	Headaches
☐	☐	Fainting Spells	☐	☐	Multiple Sclerosis
☐	☐	Liver problems	☐	☐	Parkinson's Disease
					Dementia

Surgeries

Year	Surgery Performed	Details

Physicians

Name	Specialty	Address