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 ☐ Separated

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

Details:

Surgeries		
Year	Surgery Performed	Details

Physicians		
Name	Specialty	Address