Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Surgeries:** | **Approx. Date:** |
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| **Social History Continued…** |
| Do you use any recreational drugs? |
| Do you use any prescription drugs recreationally?  |
| Do you exercise regularly? |
| How would you rate your diet? |

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| **Family Medical History:** |
| Father’s Age: | Alive or Deceased: |
| Medical Conditions: |
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| Mother’s Age: | Alive or Deceased: |
| Medical Conditions: |
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| How many brothers/and or sisters do you have, and do they have any medical Conditions?  |
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| How many children do you have, and do they have any medical conditions? |
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| Has any relative, living or deceased, ever had any of the following: (If yes, place a checkmark next to the condition) |
| Diabetes:  | Heart Disease: |
| Hypertension:  | Stroke: |
| Blood Disorders:  | Crohn’s Disease: |
| Ulcerative Colitis: | Ulcers |
| Chronic Back Pain: | Rheumatoid Arthritis: |
| Osteoarthritis: | Lupus |
| Ankylosing Spondylitis: | Psoriasis: |
| Scleroderma:  | Gout: |
| Birth Defects: | Reiter’s Syndrome: |
| Inherited or Congenital Bone/Joint Disease:  |
| Other: |

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| **Hospitalizations For Illness:** | **Approx. Date:** |
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| **List Any Medical Conditions Past or Present:** |
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| **Current Medications:** |
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| **Allergies:** |
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| **Social History** |
| Birthplace: |
| Ethnic Origin: | Education: |
| Do you smoke?  | If yes, how long? |
| How many per day? | Interested in Quitting?  |
| Do you drink alcohol? | If yes, how often? |
| How many drinks, when you do drink alcohol? |

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| **Any Additional Information:** |
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