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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