• Patient History

Have you ever been hospitalized? (If there is not enough space provided, please continue on the other side of this form.)

Date	**Hospital/Facility**	**Reason**
___/___/_____	_____	_____
___/___/_____	_____	_____
___/___/_____	_____	_____
___/___/_____	_____	_____
___/___/_____	_____	_____

• Family History

(circle correct answer)
Father: Alive / Deceased
Mother: Alive / Deceased

(fill in blank with number)
Brothers: Alive _____ Deceased _____
Sisters: Alive _____ Deceased _____
Sons: Alive _____ Deceased _____
Daughters: Alive _____ Deceased _____

• Social History

(please circle)

- Do You Smoke? Y N
  If yes, how often? _____
- Have you smoked in the past? Y N
  If yes, how often? _____
- Are you subject to second hand smoking? Y N
  If yes, how often? _____
- Do you drink alcohol? Y N
  If yes, how often? _____
- Do you do Recreational drugs? Y N
  If yes, how often? _____
- Do you drink caffeine? Y N
  If yes, how often? _____
- Do you exercise? Y N
  If yes, how often? _____

Please list any other information that may be helpful.

_____
_____
_____