**If you are unable to answer any of the questions, please bring it to the doctor's attention. This form becomes part of your medical record and is held in confidence between you and your physician.**

***Please Print***

**Name:** _____ **Date:** _____

**Social History**: Place of birth: _____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed
Military Service: ☐Yes ☐No When:_____ Where:_____ Maritime Employee: ☐Yes ☐No
International travel or lived overseas: ☐ Yes ☐ No When:_____Where:_____
Use of tobacco: ☐ Never ☐ Previously, but quit ☐ Current packs/day _____
Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐Daily
Do you use illegal drugs? ☐ Never ☐ Type/Frequency _____

**Family Medical History:**

| | Age | Diseases | If Deceased, Cause of Death |
|---|---|---|---|
| Father | ____ | _____ | _____ |
| Mother | ____ | _____ | _____ |
| Siblings | ____ | _____ | _____ |
| | ____ | _____ | _____ |
| Spouse | ____ | _____ | _____ |
| Children | ____ | _____ | _____ |
| | ____ | _____ | _____ |
| | ____ | _____ | _____ |

**Previous Surgeries and Hospitalizations:**

| Date | Hospital | Reason | Physician |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**Date of last EKG:** _____ **Female - date of last pap smear** _____
**Female- date of last mammogram** _____
**Date of last chest X-ray:** _____ **Female- dale of last menstrual period** _____

**Date of last colonoscopy:** _____ **Male- date of last prostrate check** _____
**Do you take blood thinner?** _____ **Do you take diet pills?** _____