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?** _____