SOCIAL AND PREVENTATIVE HISTORY

Patient Name: _____ DOB: _____ Date: _____

Do you currently smoke or chew tobacco? ☐ Yes ☐ No
If yes, how many packs per day? _____

If no, have you smoked in the past? ☐ Yes ☐ No

Do you drink alcohol, beer, or wine? ☐ Yes ☐ No
If yes, how many drinks per week? _____

If no, have you in the past? ☐ Yes ☐ No

Do you use any recreational drugs? ☐ Yes ☐ No
If yes, how often? _____

If no, have you in the past? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Birth control method: _____ ☐ None

Do you take supplements / vitamins ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No
Since _____/_____/_____

Do you exercise daily / weekly? ☐ Yes ☐ No
What kind of exercise? _____
How long (minutes)? _____ How often? _____

If no, why? _____

Do you currently drink coffee and/or tea? ☐ Yes ☐ No

If yes, how many cups per day? _____

Do you wear sunscreen? ☐ Yes ☐ No

Do you currently drink soda and/or energy drinks? ☐ Yes ☐ No

SAFETY:

Do you use seatbelts while driving? ☐ Yes ☐ No

Do you wear a helmet while riding a bike? ☐ Yes ☐ No

Is violence at home a concern for you? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

Do you have a gun in your home? ☐ Yes ☐ No

TESTS (Give date last done):

TEST	MONTH/YEAR PERFORMED	NOT SURE	NEVER DONE	RESULTS
Pap Smear				
Breast Exam (Self-exam)				
Mammogram				
Rectal Exam				
Colonoscopy				
Cholesterol/Lipid Profile				
Testicular (Self-exam)				
Tetanus				
STD Screening				
Thyroid Profile				
Bone Density				
Dental Exam				
Eye Exam				
Pneumonia Shot				
Flu Shot				
PSA Blood Test				

WOMEN'S HEALTH HISTORY:

Menstrual Periods:
Age Onset: _____ Problems with Breasts: _____ Date of Last Period: _____
Unusual Vaginal Discharge: _____ Periods: Regular ☐ Irregular ☐ Difficulty with Periods: _____

Pregnancies:
No. of Children Born Alive _____ No. of Cesarean Sections: _____ No. of Premature Births: _____
No. of Stillborns: _____ No. of Miscarriages: _____ No. of Abortions: _____

Describe any complications: _____

Any other health issues not mentioned above? _____ Patient Initials: _____