

Family History: No significant family history

Unknown

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

Other: _____

Please indicate if Grandparent is
Maternal or Paternal (M) or (P)

Social History

Tobacco Smoking Status: Never Current Smoker Former Smoker

If you are a former smoker, when was your quit date? _____

If you are a current smoker, how much do you smoke? _____ pack(s) per day

Have you ever used any other forms of tobacco or nicotine? Yes No

Alcohol Intake: None Moderate Occasional Heavy

Do you use any illicit or recreational drugs? Yes No

Marital Status: Single Married Divorced Widowed

Are you sexually active? Yes No

Number of Children: _____

Occupation: _____

Diet: Regular Vegetarian Vegan Gluten Free Other

Exercise Level: None Moderate Occasional Heavy

Advanced Directive: Yes No

Gender Identity

Gender Identity: Female Male Transgender Other

Sex Assigned at Birth: Female Male

Sexual Orientation: Heterosexual Homosexual Bisexual Other

Surgical History: Please list all surgeries with dates

_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History: Please list any past medical health conditions

_____	_____
_____	_____
_____	_____
_____	_____

Preventive Care: If known, please list the dates of the following screenings/vaccinations. If not applicable, please write N/A or leave blank.

Pap Smear: _____ Mammogram: _____

Bone Density: _____ Colonoscopy: _____

Pneumonia Vaccine: _____ Flu Vaccine: _____

Shingles Vaccine: _____ Tetanus Vaccine: _____

COVID Vaccine: _____