

#### **Patient Name:**

Date:

# Social History / Occupational History

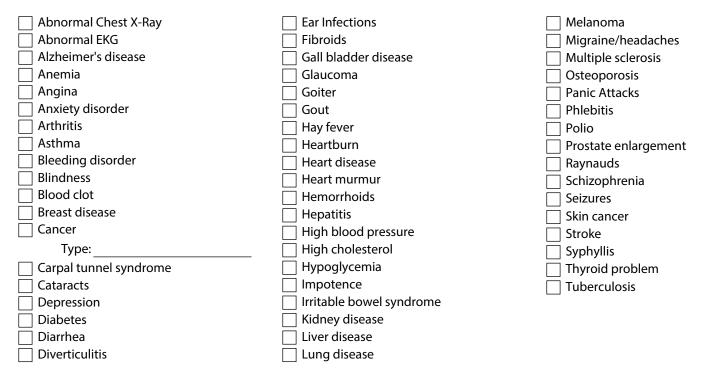
		<u>Type &amp; Amount</u>	How many years?
Do you use tobacco now?	🗌 Yes 🗌 No		
Have you used tobacco in the past?	🗌 Yes 🗌 No		
Do you use alcohol now?	🗌 Yes 🗌 No		
Have you used alcohol in the past ye	ar? 🗌 Yes 🗌 No		
Do you use recreational drugs now?	🗌 Yes 🗌 No		
Have you used recreational drugs in	the past? 🗌 Yes 🗌 No		
Marital Status: 🗌 Married	Widowed	Divorced Seperated	
Do you live: 🗌 alone	with spouse	with children 🗌 other	
Are you presently employed?	Yes 🗌 No		
Most recent occupation:			
Previous occupation(s):			
Do you have a Living Will?	Yes 🗌 No		
<u>OB / Gyn</u>		<b>Screening Histo</b> Date of your last:	сy
Age of first menstrual period:		Pap smear	
Are you periods regular?	🗌 Yes 🗌 No	Breast exam	
Date of last menstrual period:		Flu shot	
Number of pregnancies:		Pneumonia shot	
Number of live births:		Mammogram	
Menopause:	🗌 Yes 🗌 No	Colonoscopy	
Onset date:		Dexa scan	
Have you ever taken birth control pills?	🗌 Yes 🗌 No		
Have you ever taken hormone replacement therapy?	🗌 Yes 🗌 No		



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## **Past Medical History:** Please check if you have had any problems with any of the following:



### Past Surgical History: Please list your past surgeries and dates:



### **Family History:**

	Living	<u>Age or age at death</u>	List serious illnesses	If deceased: list cause of death
Mother	Yes No			
Father	🗌 Yes 🗌 No			
Sisters	Yes No			
Brothers	Yes No			
Children	Yes No			