PATIENT INFORMATION FORM

The following information will be kept in restricted confidence, released only with your authorization.

Patient Name: _____ Date: _____

MEDICAL CONDITIONS (any that require(d) medications or monitoring by health care professionals)

Condition	Date Diagnosed	Type of Treatment Received (for example Medication, Hospitalization, Chemotherapy, Radiation, etc.)	Date Resolved

SOCIAL HISTORY

What is your occupation?	
Do you regularly exercise? ☐Yes ☐No **(Type of exercise _____.)**	**Average # of times per week _____.** **Average # of minutes per session _____.**
Do you regularly drink alcohol? ☐Yes ☐No	**Average # per day _____. Circle type: wine ☐ / beer ☐ / hard liquor ☐** **Average # per week _____.**
Do you drink caffeinated beverages? ☐Yes ☐No	**Average # per day _____. Circle type: coffee ☐ / tea ☐ / soda ☐**
Do you currently smoke? ☐Yes ☐No	**Age started _____. Average # of packs per day _____.**
Are you a former smoker? ☐Yes ☐No	**Age started _____. Age quit smoking _____.** **Average # of packs per day _____.**
Ever use recreational drugs? ☐Yes ☐No	**Type _____. Circle: current use ☐ / past use ☐**

FAMILY HISTORY

Relative	Medical Problems / Cause of Death	If deceased, age at death
Mother		
Father		
Sisters		
Brothers		
Children		
Grandmother	**Maternal: Paternal:**	**Mat: Pat:**
Grandfather	**Maternal: Paternal:**	**Mat: Pat:**
Aunts	**Maternal: Paternal:**	**Mat: Pat:**
Uncles	**Maternal: Paternal:**	**Mat: Pat:**