Medical History

Patient Name: _____ **Date:** _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Race : ☐ ☐ Asian ☐ ☐ Black ☐ White ☐ Hispanic

Education:
Highest grade completed (circle one):
1 2 3 4 5 6 7 8 9 10 11 12
☐ Some college/technical school
☐ College Graduate
☐ Graduate school/advanced degree

Social History Cultural/Religious
Any customs or religious beliefs or wishes that might affect care? Please note:
_____

Employment/Work (Job/School/Play)
☐ Working full-time ☐ Working part-time
☐ Homemaker ☐ Student ☐ Retired
☐ Unemployed
Occupation_____

General Health Status
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Social/Health Habits
Currently smoke tobacco: ☐ Yes ☐ No
Quit: _____/_____/_____

Alcohol
How many days per week do you drink beer, wine or other alcoholic beverages, on average? _____ # Per day? _____

Exercise
Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No
If yes, describe exercise: _____
How many days per week? _____
How many minutes per day? _____

Hobbies: _____

Intimate Partner Relationship
☐ Good ☐ Bad ☐ N/A

Living Environment
Where do you live?
☐ Private home
☐ Private Apartment
☐ Rented Room
☐ Board & care/assisted living/group home

Does your home have:
☐ Stairs, no railing
☐ Stairs, railing

Do you use:
☐ Cane ☐ Walker or rollator

With whom do you live?
☐ Alone
☐ Spouse Only
☐ Spouse & other(s)
☐ Other relative(s) (not spouse or child)
☐ Group setting
☐ Personal care attendant
☐ Other: _____

Do you have:
☐ Siblings

Do you have Children?
☐ Yes ☐ No
If Yes, how many? _____
Ages: _____

Additional Information:
Advanced Directive ☐ Yes ☐ No
Diet_____
Stress Level: ☐ Low ☐ Average ☐ High
Sexually Active: ☐ Yes ☐ No
Illicit Drug Use: ☐ Yes ☐ No
Is there a gun in your home? ☐ Yes ☐ No
Do you drive a car? ☐ Yes ☐ No