**NAME**:

To expedite your visit we ask that you take the time to fill out the brief histories below.

**Social History**

|  |
| --- |
| **Tobacco Use:** Current Smoker Former Smoker Never Smoked Social Smoker Vaping Chewing tobacco **If yes,** how many cigarettes do you smoke per day? \_\_\_\_\_\_ **Are you exposed to** **Secondary Smoke?** Yes No **If yes**  Outside  Inside**Alcohol Use:** No, Never  Yes, how many days do you drink per week /or/ per month Former Drinker Recovering Alcoholic   |
| **Do you use street drugs?** Yes If yes, what kind? No |
| **Caffeine:** Do you drink Caffeine? Yes **If yes,** how many cups per day? \_\_\_\_\_\_\_  No  |
| **Exercise:** None  Regular exercise Occasional exercise Inconsistent exercise Active lifestyle-no organized exercise routine What type of exercise do you do? |
|  |

**NAME:**

**Family History**

 *Check here, If you are Adopted and do not know your family’s medical history.*

Does your **Mother, Father, Brother, or Sister** have any of the following?

**Stroke**

Mother Father Brother Sister No one

**Heart Attack**

Mother Father Brother Sister No one

**Blood Clot**

Mother Father Brother Sister No one

**Diabetes**

Mother Father Brother Sister No one

**High Cholesterol**

Mother Father Brother Sister No one

**High Blood Pressure**

Mother Father Brother Sister No one

**Breast Cancer**

Mother Father Brother Sister No one

**Ovarian Cancer**

Mother Father Brother Sister No one

**Prostate Cancer**

Mother Father Brother Sister No one