Name: ____**Date of Birth:** __________ **Date:** _________
Marital Status: ☐ S ☐ M ☐ D ☐ W Sex: ☐ M ☐ F
Children: ☐ Y ☐ N **How many**: _____ **Ages:** _____________________
Occupation: _______________________ **Employer:** ___________________________ **Military:** ☐ Y ☐ N
Handedness: ☐ Right ☐ Left

Social History:

- Cigarette Smoking or Tobacco Use: ☐ Y ☐ N How many packs/day: ☐ <1 pack/day ☐ 1 or >1pack/day
  - Number of Years of Smoking: ______
  - Vaping: ☐ Y ☐ N
- Alcohol Use: ☐ Y ☐ N How often: ☐ Daily ☐ Weekends ☐ Socially ☐ Rarely
- Recreational Substances: ☐ Marijuana ☐ Cocaine ☐ Other ___________________
- Exercise Regularly: ☐ Y ☐ N ☐ 3-4 times/week ☐ daily ☐ Weekly
- Special Diet: ____________________ ☐ Low Fat/Low Cholesterol ☐ High Fiber ☐ Low Salt
- Hobbies: ____
- Education: ☐ High School ☐ College ☐ Graduate School ☐ Degree________________________
- Living Arrangements: ☐ Own Home ☐ Rent ☐ Condo ☐ living with: ______________________
- Occupational Hazardous Exposure: ☐ Y ☐ N ☐ Blood/Body Fluids ☐ Toxins ☐ Other________
- Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other

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Medication Allergies: ☐ Y ☐ N

Medication Name: _____________________________ **Reaction:** _________________________

Current Medications:
(prescription & over the counter)

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Have you ever been diagnosed with any medical conditions: ☐ Y ☐ N

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☐
☐

Have you ever had any surgeries: ☐ Y ☐ N

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☐
☐
☐
☐

Family History:

☐ Heart Disease
☐ Hypertension
☐ Diabetes
☐ High Cholesterol
☐ Thyroid Disorders
☐ Kidney Disease
☐ Cancers: ____________
☐ Psychiatric Illness ___________
☐ Other: ______________