



SOCIAL HISTORY

Marital Status Married Separated Divorced Widowed Single

Number of Children: _____ With whom do you live? _____

Family Physician (PCP): _____

Other Physicians: 1. _____
2. _____

Are you retired? YES NO

What is your occupation? _____ Retired N/A

How stressful is your job? Very Moderately Mildly Not N/A

Do you take your prescribed medications regularly?

1. Always 2. Most of the time 3. I frequently skip doses

Have you previously smoked?

1. Never
2. Yes, I quit Year quit: _____ # of packs/day _____ #of years smoking: _____
3. Currently smoking: _____ # of packs/day _____
Cigars Pipe Chew tobacco _____ times/day

Do you drink alcohol?

1. Never
2. No, but I quit. Year: _____
3. Yes _____ glasses/week of: wine beer liquor

Do you take illicit drugs or abuse prescription medications?

1. Never 2. No, but I used to 3. Yes DETAILS: _____

Do you drink caffeine?

No Yes (*circle all that apply*) Coffee Tea Soft Drinks _____ drinks/day

How many times/week do you exercise? _____

Do you follow any special diet or dietary restrictions? Yes No

If Yes, please explain: _____