

NAME: _____

Social/Lifestyle History

1. Marital Status: Single Married Divorced Separated Widowed

2. Employment History: Unemployed Disabled Retired Employed: Full-time Part-time
Type of work done now or in the past: _____

3. Living Arrangements: Live alone Live with: _____

4. Frequency of Exercise: Never Rarely Once/twice weekly Several times weekly

5. Tobacco Use

A. Do you smoke, "chew", or "dip" now or in the past? NO YES
If Yes: Cigarettes Pipe Cigars Chewing Tobacco Snuff

B. Average number of packs of cigarettes that you smoke now or used to smoke per day:
 less than 1/2 1/2 - 1 1-2 2 or more

C. Number of months or years smoking currently or in the past: _____ months / years

D. Have you ever tried quitting? NO YES If yes, how many times? ____ For how long? _____

E. If you have permanently quit, when? _____

6. Alcohol Use:

A. Do you drink alcohol now? NO YES
If you have permanently quit, when? _____

B. Have you ever had a problem with drinking alcohol? NO YES

C. Has anyone close to you ever thought you drank too much? NO YES

D. How much of the following do you consume?
Number of 12 ounce cans of beer: daily _____ or weekly _____ or monthly _____
Number of 8 ounce glasses of wine: daily _____ or weekly _____ or monthly _____
Number of shots (shot = 1 1/2 ounces) liquor: daily _____ or weekly _____ or monthly _____

7. Drug Use:

Current or past use of marijuana or other drugs? NO YES If Yes, what? _____
How often: _____ Last time used: _____

8. Caffeine Drinks:

Coffee: None 1-2 3-6 7 or more cups daily or weekly
Tea: None 1-2 3-6 7 or more cups daily or weekly
Soft Drinks: None 1-2 3-6 7 or more cups daily or weekly

9. You are not required to answer the following questions, however, the answers may help your health care provider give you better advice and treatment.

A. Are you currently sexually active? NO YES
If Yes, do you find your sexual life to be satisfactory? NO YES SOMETIMES

B. Do you have more than one sexual partner per year? NO YES

C. What is your sexual orientation? Heterosexual (opposite sex only) Homosexual Bisexual

D. Have you now or in the past felt physically, emotionally, or verbally abused, or been hit, kicked, punched, or slapped?
 NO YES If Yes, explain: _____

E. **Religious Affiliation:** None Baptist Methodist Catholic Christian
 Other: _____

Patient Signature: _____ Date: _____

Reviewed by _____ Date: _____