

Past Family and Social History (PFSH)

Instructions: Please fill out this form **COMPLETELY**. Please **INCLUDE ANY EXPLANATIONS IN THE SPACE PROVIDED**. Also, please indicate the source of this information:

Current and Past Medical History - Please list current and past medical history for **YOURSELF**.

Female Patients Only

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma/Emphysema	Last menstrual period: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	Deliveries - # vaginal _____
<input type="checkbox"/> Other - Please explain below: _____	<input type="checkbox"/> High Cholesterol	# Caesarean _____

Physician Notes: NC _____ UO _____

Surgical History - Please list chronologically any surgeries performed on **YOU**, beginning with the most recent.

Physician Notes: NC _____ UO _____

Family History - Please indicate current and past medical problems of **YOUR FAMILY MEMBERS**.

<input type="checkbox"/> Prostate cancer - family member: _____	<input type="checkbox"/> Heart Disease - family member: _____
<input type="checkbox"/> Kidney stones - family member: _____	<input type="checkbox"/> Diabetes - family member: _____
<input type="checkbox"/> Other - Please explain below: _____	

Physician Notes: NC _____ UO _____

Social History - Please indicate the following as it pertains to **YOU**.

What is your occupation? _____

Marital Status: Single Married Widowed Divorced

Do you have children? No Yes # of Children and Ages: _____

Do you use tobacco products now? No Yes # of packs per day _____ for _____ year(s)

Have you used tobacco in the past? No Yes # of packs per day _____ for _____

Do you use alcohol products? No Yes # of cocktails/beer/wine per week _____

Do you use other drugs? No Yes What types? Marijuana Other: _____

Additional Information: _____ Physician Notes: NC _____ UO _____

ALLERGIES- (Drugs, Food, Environmental, Other) Please List: NONE Seafood

_____ NKDA

CURRENT MEDICATIONS Please List: Daily Aspirin Oral Contraceptives See Attached List _____

_____ NONE

Source: Patient Family/Friend Past Medical Records _____

Physician Reviewed and Confirmed: _____, M.D. Date: _____

PFSH