Past Medical History and Social History

Name: ______________________________ Date: ______________

Occupation: ____

Thank you for taking the time to complete and update your past/social history. This information is used solely by your doctor in evaluating your health concerns. This is privileged information and is protected by law. Be as accurate as you can. Please give approximate dates in month/year.

Current Chronic Conditions

____

____

Surgeries/Hospitalizations: Dates:

____

____

Medications: ______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

Vitamins/Supplements: ______________________________________

Other providers / Specialists / Ongoing Therapies ______________________________

Allergies: ______________________________________

Family History: Provide information for your natural relatives only. Unnecessary if you're over 75

Condition	Father	Mother	Grandparents	Siblings	Children
Allergy/Asthma					
Alcohol Abuse					
Arthritis/Gout					
Bleeding Disorder					
Colon Cancer					
Breast Cancer					
Prostate Cancer					
Glaucoma					
Heart Attack under 65					
Diabetes					
High Cholesterol					
Stroke					
Suicide					
Bipolar Disorder					
Depression					
Anxiety					
Thyroid Disease					
Alzheimer's					
Kidney Disease					
Osteoporosis					
Age					
Age at Death					
Cause of Death					

Family: Are you presently: Married Never Married Divorced Widowed

I've been in my current status since: ___ How many marriages: ___ How many divorces: ___

Who are you currently living with? Spouse Friend Roommate Family Member Alone

How many children do you have? _____ What states do they live in? ______________

Social History: Hobbies/Interests ______________________ Exercise ______________

Habits: Nicotine: ____ ETOH (Alcohol): _____ Caffeine: _____ Recreational Drugs: _____

Do you have an updated Will? Yes No Do we have copies of your Advance Directive? Yes No

Childbirth: Pregnancies___ Miscarriages ___ Abortions ___ Births ___

Annual Review/ Personal Medical History

Name:______________________________ Date:______________________

Please review the items below and mark those that have appeared during the last 12 months only.
Make comments regarding those you marked in the space below.

CONSTITUTIONAL		GASTROINTESTINAL (cont.)		METABOLIC / ENDOCRINE (cont.)	
Chills		Heartburn		Change in Appetite	
Fatigue		Loss of Appetite		NEUROLOGICAL	
Fever		Nausea		Dizziness	
Malaise		Vomiting		Extremity Numbness	
Night Sweats		GENITOURINARY		Extremity weakness	
Weight Gain		Dribbling		Gait Disturbance	
Weight Loss		Painful Urination		Headache	
EAR NOSE AND THROAT		Blood in Urine		Memory Loss	
Ear Drainage		Increased Urine Volume		Seizures	
Ear Pain		Slow Stream		Tremors	
Eye Discharge		Urinary Frequency		PSYCHIATRIC	
Eye Pain		Urinary Incontinence		Anxiety	
Hearing Loss		Urinary Retention		Depression	
Nasal Drainage		REPRODUCTION (FEMALE)		Insomnia	
Sinus Pressure		Abnormal Pap		SKIN	
Sore Throat		Breast Discharge		Contact Allergy	
Visual Changes		Breast Lump		Hives	
RESPIRATORY		Menstrual Cramps		Itching	
Chronic Cough		Pain with Intercourse		Mole Changes	
Cough		Hot Flashes		Rash	
Known TB exposure		Irregular menses		Skin Lesion	
Shortness of Breath		REPRODUCTION (MALE)		MUSCULOSKELETAL	
Wheezing		Erectile dysfunction		Back Pain	
CARDIOVASCULAR		Penile discharge		Joint Pain	
Chest Pain		Sexual Dysfunction		Joint Swelling	
Leg Pain with Exercise		METABOLIC / ENDOCRINE		Muscle Weakness	
Edema		Brittle Hair		Neck Pain	
Palpitations		Brittle Nails		HEMATOLOGICAL/LYMPHATIC	
GASTROINTESTINAL		Cold Intolerance		Easy Bleeding	
Abdominal Pain		Hair Changes		Easy Bruising	
Blood in Stools		Heat Intolerance		IMMUNOLOGIC	
Change in Stools		Increased Body Hair		Environmental Allergies	
Constipation		Increased Thirst		Food Allergies	
Diarrhea				Seasonal Allergies	

Have you had surgery this year?		Have you updated your Will this year?	
Were you hospitalized this past year?		Have you made out Advanced Directives?	
Have you had to visit the ER this year?		Do you have an exercise program?	
Do you feel unsafe driving a car?		Did you start or quit smoking this year?	
Any new major disease in your family?		Do you need to cut down on alcohol?	
Did you get a flu shot this past year?		Do you use marijuana, cocaine or meth?	
Did you get any other shots this year?		Were you married or divorced during the year?	
Do you take a multivitamin?		Did you move during the year?	
At any time have you felt afraid of your partner?			

Comments on the above or other concerns you might have: ______________________________

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Annual questionnaire

Once a year, all our patients are asked to complete this form because these factors can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: ____________________

Date of birth: ____________________

Alcohol: One drink =

12 oz. beer 5 oz. wine 1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○

Mood:

	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

Tobacco:

Have you ever used tobacco? ○ No / Never ○ Yes ○ Previously / Quit
If yes, what type?

○ Cigarette ○ Pipe ○ Cigar ○ Chewing ○ Other – please specify ____________
○ Daily Use?
○ Quantity per day __________ How many years ____________
○ Age started ______________ Age Stopped ______________

Are you exposed to second hand smoke? ○ Environmental (home) ○ Occupational (work)

Check Your Risk for Falling

Please circle "Yes" or "No" for each statement below.			Why it matters
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
Total_____		Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.	

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. *J Safety Res*; 2011:42(6)493-499). Adapted with permission of the authors.