Social History

Please completely fill in the selected bubbles.

Caffeine:

Do you consume caffeine? O Yes O No

If Yes: How often? O Daily O Rarely O Occasionally

Alcohol:

Do you consume alcoholic beverages? O Yes O No

If Yes: How often did you have a drink containing alcohol in the past year?

O Never O Monthly or less O 2 to 4 times a month

O 2 to 3 times per week O 4 or more times a week

Recreational Drug Use:

Do you use recreational drugs? O Yes O No

O Past history of drug use O Not currently using

Smoking Status:

Are you a: O Current smoker O Former Smoker O Never Smoker

O Current smokeless tobacco user O Current Cigar Smoker

O Former Smoker - uses E-Cig O Unknown if ever smoked

O Light tobacco smoker O Heavy tobacco smoker

If "Former Smoker ": How long ago did you quit?

O Less than 1 year O 1-5 years ago O 5-10 years ago O More than 10 years ago

If "Current smoker ": How often do you smoke?

O Less than 1 pack O 1 to 2 packs O More than 2 packs

Exercise:

Do you currently exercise? O Yes O No O Unable to exercise

If "Yes": How often?

O Daily O Weekly O Rarely O On an irregular basis

Flu Vaccine:

Have you had a flu shot since the most recent September 1? O Yes O No

Have you had a flu vaccine between October 1 - March 31?

O Yes O No Date of last flu shot _____

Pneumonia Vaccine:

Is the patient over age 65? O Yes O No

If Yes: Has the patient ever had a Pneumonia vaccine?

O Yes O No Date of last Pneumonia vaccine_____

Fall Assessment:

Is the patient 65 years or older? O Yes O No

If Yes: In the past year has the patient fallen 2 or more times? O Yes O No

Patient Name :_____ DOB:_____