



BON SECOURS MEDICAL GROUP

## SOCIAL HISTORY

Living Will?  Yes  No      Power of Attorney?  Yes  No

1. Do you have any allergies?  Yes  No

If yes, Please specify medication and reaction: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Name any physician(s) currently attending you. \_\_\_\_\_

3. List any hospitalization(s) and/or surgeries you have had. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Immunizations/Tuberculosis

If you have had the following, list year of most recent vaccination:

Tetanus: \_\_\_\_\_ Flu: \_\_\_\_\_ Pneumovax: \_\_\_\_\_

Hepatitis B: \_\_\_\_\_ Measles: \_\_\_\_\_ Rubella: \_\_\_\_\_

If you have been previously skin tested for tuberculosis, year of test: \_\_\_\_\_

Result:  negative (no reaction)  positive

5. **To be completed by women:** Do you currently take birth control pills?  Yes  No

Last menstrual cycle started \_\_\_\_\_ and ended \_\_\_\_\_

Average length of cycle? \_\_\_\_\_ days. Is your menstrual flow normal?  Yes  No

Number of children \_\_\_\_\_ Number of pregnancies \_\_\_\_\_ Number of miscarriages \_\_\_\_\_

6. Check any of the following problems that apply to you.

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Acid indigestion or heartburn | <input type="checkbox"/> Diarrhea                    | <input type="checkbox"/> High blood pressure            | <input type="checkbox"/> Skin disease, frequent boils  |
| <input type="checkbox"/> AIDS                          | <input type="checkbox"/> Discomfort on moving bowels | <input type="checkbox"/> Inflamed eyes                  | <input type="checkbox"/> Sore throat                   |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Intestinal parasites           | <input type="checkbox"/> Stiff joints                  |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Double Vision               | <input type="checkbox"/> Irregular heart beat           | <input type="checkbox"/> Stomach pain                  |
| <input type="checkbox"/> Back trouble                  | <input type="checkbox"/> Ear aches                   | <input type="checkbox"/> Joint Pain                     | <input type="checkbox"/> Stress or anxiety             |
| <input type="checkbox"/> Bad teeth or dentures         | <input type="checkbox"/> Epilepsy or seizures        | <input type="checkbox"/> Joint swelling                 | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Black bowel movements         | <input type="checkbox"/> Fainting spells             | <input type="checkbox"/> Kidney disease/stones          | <input type="checkbox"/> Swallowing difficulty         |
| <input type="checkbox"/> Blood in bowel movement       | <input type="checkbox"/> Fast heart beat             | <input type="checkbox"/> Kidney or bladder infection    | <input type="checkbox"/> Syphilis                      |
| <input type="checkbox"/> Blurred vision                | <input type="checkbox"/> Frequency urinating         | <input type="checkbox"/> Malaria                        | <input type="checkbox"/> Thyroid problems              |
| <input type="checkbox"/> Burning when urinating        | <input type="checkbox"/> Frequent headaches          | <input type="checkbox"/> Muscle aches                   | <input type="checkbox"/> Tightness in chest            |
| <input type="checkbox"/> Change in weight              | <input type="checkbox"/> Frequent nosebleeds         | <input type="checkbox"/> Muscle pain                    | <input type="checkbox"/> Trouble controlling urine     |
| <input type="checkbox"/> Chest pain                    | <input type="checkbox"/> Gallbladder problems        | <input type="checkbox"/> Muscle weakness                | <input type="checkbox"/> Trouble getting urine started |
| <input type="checkbox"/> Cocaine or other drug use     | <input type="checkbox"/> Gonorrhea                   | <input type="checkbox"/> Poor appetite                  | <input type="checkbox"/> Trouble sleeping              |
| <input type="checkbox"/> Cold hurts my fingers         | <input type="checkbox"/> Hair falling out            | <input type="checkbox"/> Prostate problems              | <input type="checkbox"/> Ulcers                        |
| <input type="checkbox"/> Constipation                  | <input type="checkbox"/> Heart disease               | <input type="checkbox"/> Pus, albumin or sugar in urine | <input type="checkbox"/> Vomiting or nausea            |
| <input type="checkbox"/> Coughing                      | <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Rheumatic Fever                | <input type="checkbox"/> Weakness of an arm or leg     |
| <input type="checkbox"/> Coughing up blood             | <input type="checkbox"/> Hemorrhoids                 | <input type="checkbox"/> Rheumatism                     | <input type="checkbox"/> Weakness or tiredness         |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Shortness of breath            | <input type="checkbox"/> Wheezing                      |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Hernia                      | <input type="checkbox"/> Sinus problems                 | <input type="checkbox"/> Yellow jaundice               |

7. Please list any immediate family members who have experienced the following:

Cancer & type:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	
Diabetes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	
Heart disease:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	
Mental illness:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	
High blood pressure:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	
Stroke:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	
Any other serious illness:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	

Place patient label inside box (if no patient label, complete below)

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

MR #: \_\_\_\_\_



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### SOCIAL HISTORY

Place patient label inside box (if no patient label, complete below)

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

MR #: \_\_\_\_\_

<b>Social History</b>			
<b>Marital Status</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Partnered	<input type="checkbox"/> Separated
	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<b>Living</b>	<input type="checkbox"/> Live alone	<input type="checkbox"/> Live with significant other	
	<input type="checkbox"/> Live with spouse	<input type="checkbox"/> Live with other	
Race: _____ Ethnicity: _____			
<b>Employment</b>	<input type="checkbox"/> Occupation/ Employer →		
	<input type="checkbox"/> Homemaker		
	<input type="checkbox"/> Student (where, major, year) →		
<b>Tobacco</b>	<input type="checkbox"/> NO - I do not smoke and have never smoked		
	<input type="checkbox"/> YES - I previously smoked but no longer smoke	Quit Date?	
		Previous # of packs per day?	
	<input type="checkbox"/> YES - I am currently smoking	Previous # of yrs smoking?	
		Number of packs per day?	
		Number of years smoking?	
<b>Alcohol</b>	<input type="checkbox"/> NO - I do not drink any alcohol		
	<input type="checkbox"/> YES - I previously drank alcohol but no longer drink alcohol	Quit Date?	
		Type of alcohol?	
		Number of drinks per week?	
		Years drinking?	
	<input type="checkbox"/> YES - I drink alcohol	Type of alcohol?	
		Number of drinks per week?	
		Years drinking?	
<b>Drugs</b>	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	What type of street drugs have you used in the past or are currently using?		
<b>Sexual History</b>	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you currently trying to become pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying to become pregnant, list contraceptive or barrier method using:		
	When was your last menstrual period? How many periods do you have per year?		
<b>Military History</b>	Have you ever been in the military service?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If so, which branch?	<input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard <input type="checkbox"/> Reserves <input type="checkbox"/> Other	