PATIENT HISTORY

Name_____

CURRENT MEDICATIONS **Date Started** **Strength** **Dosage** **Frequency**

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SURGERIES **Year** **Type**

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HOSPITALIZATIONS **Date** **Reason**_____

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MAJOR ILLNESSES **Date**

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ALLERGIES **Reaction**

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Hours of sleep since injury _____

Hours of sleep before injury _____

Profession_____ **Date Started**_____

Smoker (cigarettes, chewing, pipe, e cigarette, hookah) ◯**Never** ◯ **Former** ◯ **Current Every Day** ◯ **Current Some Day**

◯ **Less than 10/day(light)** ◯**More than 10 times/day (heavy)**

Alcohol ◯**Never** ◯**Casual/Occasional** ◯**1-2 per day** ◯ **greater than 2 per day** ◯**Binge** ◯ **Beer** ◯ **Wine**

Caffeine (daily) ◯**None** ◯**Less than 3** ◯ **3-6** ◯ **More than 6**

Drug use ◯ **None** ◯**Recreational** ◯ **Addiction** ◯ **Opiate** ◯ **Sedative** ◯ **Amphetamine** ◯ **Hallucinogen**

Exercise ◯**Never** ◯ **Daily** ◯ **Weekly** ◯ **Walk** ◯ **Run** ◯ **Swim** ◯ **Bicycle** ◯**Aerobic** ◯ **Yoga**

Vaping ◯ **Never** ◯ **1-4x/day** ◯ **More than 4x/day**

Water Consumption ◯ **None** ◯**1-3 glasses** ◯ **4-6** ◯ **6-8** ◯ **More than 8**

Are you ◯**Married** ◯**Single** ◯ **Divorced** ◯ **Widowed** ◯ **Living alone** ◯**Living with someone else**

FAMILY MEDICAL HISTORY

	Major Illnesses	Living/Deceased	Cause of Death
Mother	_____	◯ **L** ◯**D**	_____
Father	_____	◯ **L** ◯**D**	_____
Sibling ◯**Male** ◯**Female**	_____	◯ **L** ◯ **D**	_____
Sibling ◯**Male** ◯**Female**	_____	◯**L** ◯**D**	_____
Sibling ◯**Male** ◯**Female**	_____	◯**L** ◯**D**	_____
Sibling ◯**Male** ◯**Female**	_____	◯**L** ◯**D**	_____
Sibling ◯**Male** ◯**Female**	_____	◯**L** ◯**D**	_____
Sibling ◯**Male** ◯**Female**	_____	◯**L** ◯**D**	_____
Maternal Grandmother	_____	◯**L** ◯**D**	_____
Maternal Grandfather	_____	◯**L** ◯**D**	_____
Paternal Grandmother	_____	◯**L** ◯**D**	_____
Paternal Grandfather	_____	◯**L** ◯**D**	_____