Patient Name

Social History

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Social History

1. Diet (Circle one)

Regular Vegetarian Vegan Gluten free

Specific Carbohydrate Cardiac Diabetic

2. Caffeine intake (Circle one)

None Occasional Moderate Heavy

3. Exercise level (Circle one)

None Occasional Moderate Heavy

4. Sporting activities _____

5. Parents' marital status (Circle one)

Married Unmarried Separated Divorced

Widowed

6. Home situation (Circle one)

Both parents Mother Father Relatives

Adoptive parents Foster parents Other

7. Siblings _____

8. Childcare? (Circle one)

None Relative Private sitter Daycare/preschool

9. Animal exposure? (Circle one)

Yes No

10. Passive smoke exposure? (Circle one)

Yes No

11. Smoke/CO detectors in home? (Circle one)

Yes No

12. Seat belt/car seat used routinely? (Circle one)

Yes No

13. Sunscreen used routinely (Circle one)

Yes No

14. Insect repellent used routinely? (Circle one)

Yes No

15. Year in school (Circle one)

Pre-K	Kindergarten	1	2
3	4	5	6
7	8	9	10
11	12	HS Grad	College

16. School name _____

17. Smoking Status (Circle one)

Never smoker	Former smoker	Current every day smoker	Current some day smoker
Smoker - current status unknown	Unknown if ever smoked		