



Social History

Shoe Size

Right Handed

Left Handed

Single

Married/Partner

Widowed

Other

Do you now or have you ever smoked?

Yes

No

Former

If so, amount per day

Year stopped smoking

Do you drink alcohol?

Yes

No

If so, number of drinks per day, week or month?

Do you drink caffeinated drinks?

Yes

No

If so, how many per day?

Employer Name

Occupation

If Retired - What was your occupation?

Who referred you?

How did you hear about this office?

Patient signature

Date