Patient Name_____Date of Birth:_____

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (Mom's)	A	D		
Grandfather (Mom's)	A	D		
Grandmother (Dad's)	A	D		
Grandfather (Dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Social History

Occupation:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No How many?_____

Do you live alone? ☐Yes ☐No Who lives with you?_____

Do you smoke? ☐Yes, I've smoked_____packs of cigarettes per day for _____years.
☐ Yes, I smoke cigars or a pipe.
☐ No, I have never smoked.
☐ No, I quit_____years ago. At that time I was smoking_____packs per day for _____ years.

Do you drink alcohol? ☐ No, never (or rarely) ☐ No, but I used to
☐Yes ☐Daily ☐ 1 or more times a week ☐ 1 or more times a month

Are you at risk for AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion)? ☐ No ☐ Yes, please explain:_____