



Client Label Here

**Social History** (Check all that apply)

Smoke tobacco       Chew tobacco       Use to smoke/chew tobacco. Quit date: \_\_\_\_\_

How many cigarettes do you smoke a day? \_\_\_\_\_

Vape

Drink alcohol       How many drinks do you have per day?

Use street drugs?  
If yes, how recently and what did you use? \_\_\_\_\_

Have you used IV drugs (needles)?  Yes    No

Has your partner used IV drugs (needles)?  Yes    No

**Family History** (Check all that apply)

Have any of your immediate family members (Mother, Father, Brother, Sister, Grandparents, Aunt/Uncle, etc.) ever had:

Heart attack before age 50       High cholesterol       Menopause before age 45

High blood pressure       Diabetes       Mental Illness

Stroke       Breast or reproductive organ cancer       Compression fractures

Other: \_\_\_\_\_