



SPRING CITY
Health Centre

403 N. Grand Ave Waukesha, WI 53186
262-547-3055

PAST MEDICAL, FAMILY, AND SOCIAL HISTORY

PATIENT NAME: _____ DOB: _____

MEDICATIONS (RX & OTC) (NAME AND DOSAGE)

PAST MEDICAL HISTORY/ SURGERIES

SOCIAL HISTORY

MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated	ALCOHOL: <input type="checkbox"/> YES <input type="checkbox"/> NO
OCCUPATION: _____	DRUGS: <input type="checkbox"/> YES <input type="checkbox"/> NO
SMOKING: <input type="checkbox"/> YES <input type="checkbox"/> NO Packs Per Day _____ <input type="checkbox"/> Quit, How long ago _____	CAFFEINE: <input type="checkbox"/> YES <input type="checkbox"/> NO
EXERCISE: <input type="checkbox"/> YES <input type="checkbox"/> NO	
DIET: _____	

FAMILY MEDICAL HISTORY

FATHER: _____
MOTHER: _____
SIBLINGS: _____
GRANDPARENTS: _____

I HAVE READ AND REVIEWED THE ABOVE AND HAVE NO CHANGES.

PATIENT SIGNATURE _____ UPDATED _____

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PATIENT SIGNATURE _____ UPDATED _____

PATIENT SIGNATURE _____ UPDATED _____

PATIENT SIGNATURE _____ UPDATED _____