

SOCIAL HISTORY

SUBSTANCES:

Tobacco Use

Please check one:

- I have never smoked.
 I have smoked, but rarely.
 When was the last time? _____
 I have quit smoking. Quit: Date _____
 I currently smoke _____ pack(s)/day, # of yrs. _____
 Other Tobacco: Pipe Cigar Snuff Chew
 Are you interested in quitting? No Yes

Alcohol Use

Do you drink alcohol? Never Occasionally Regularly
Average# drinks/week: _____ 5 oz glasses wine;
 _____ 12 oz cans beer; _____ 1.5 oz shots hard liquor
Is alcohol use a concern for you or others? No Yes

Drug Use

Do you use any recreational drugs? No Yes
Have you ever used needles? No Yes

SEXUALITY:

Sexual Activity

Sexually Active: Yes No Not currently
Current sex partner(s) is/are: male female

Contraception and Protection

Birth Control method: _____ None needed
If sexually active, do you practice safe sex? NA No Yes
Have you ever had any sexually transmitted diseases (STDs)?
 No Yes

If yes, please include: _____ date _____
Are you interested in being screened for sexually transmitted diseases?
 No Yes

Other concerns? _____

SAFETY:

Do use seatbelts consistently? No Yes
Do you use a bike helmet regularly? NA No Yes
Is violence at home a concern for you? No Yes
Are you currently in a relationship? No Yes
 If yes, do you feel safe in this relationship? No Yes
Do you have a gun in your home? No Yes
Other concerns? _____

EXERCISE:

How active are you?
 I get a cardiovascular work-out 3 or more times/week.
 I walk daily but do not work out.
 I exercise or walk less than 3 times/week.
 I am not generally active.
 [other] _____

PREFERRED PHARMACY: _____
Include Address if not HVMA Pharmacy

SOCIOECONOMICS:

Ethnic Background: How would you best describe yourself?
(check only one)

- Asian Black, Non-Hispanic Hispanic
 Native American Native Hawaiian & Other Pacific Islander
 White, Non-Hispanic Other Decline

Marital status: Single Married Sep Div Widow
 Co-habiting Engaged... Other _____
Spouse/Partner's name: _____

Number of children: _____
Who lives at home with you? _____

Occupation: _____

Education completed: Grade school High school
 College Graduate school

EMOTIONS:

1. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed?
 No Yes
2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?
 No Yes
3. Have you felt depressed or sad much of the time in the past year?
 No Yes

IMMUNIZATIONS:

Please list your most recent immunizations. You do NOT need to include any immunizations given at Harvard Vanguard Medical Associates. Please include your best estimate of the month and year of each immunization:

Hepatitis A ____ Measles ____ Mumps ____ Rubella ____ Pneumovax (Pneumonia) ____
Hepatitis B ____ MMR ____ Meningitis ____ Shingles ____
HPV ____ Varicella (chicken pox) shot ____ Other ____
Tetanus (Td) ____ TdaP ____

REVIEW OF SYMPTOMS: Please check (√) any current problems you have on the list below.

Breasts

___ Breast pain/lump/discharge

Constitutional

___ Fevers/chills/sweats
___ Unexplained weight loss/gain?
___ Fatigue/weakness

Eyes

___ Change in vision

Ears/Nose/Throat/Mouth

___ Difficult hearing
___ Ringing in ears
___ Problems with teeth/gums
___ Hay fever/allergies

Respiratory

___ Cough/wheeze
___ Difficulty breathing

Cardiovascular

___ Chest pain/discomfort
___ Leg pain with exercise

___ Palpitations

Gastrointestinal

___ Abdominal pain
___ Heartburn
___ Bloody/black bowel movement
___ Nausea/vomiting/diarrhea
___ Constipation
___ Change in bowel habits

Genitourinary

___ Nighttime urination
___ Difficulty starting urination
___ Leaking urine
___ Painful urination
___ Blood in urine
___ Discharge from penis
___ Sexual function problems

Musculoskeletal

___ Muscle/joint pain or swelling

Neurological

___ Headaches
___ Dizziness/light-headedness
___ Numbness
___ Memory loss
___ Loss of coordination

Psychiatric

___ Anxiety/stress
___ Problems with sleep
___ Depression

Skin

___ Rash or mole change
___ Itching

Blood/Lymphatic

___ Unexplained lumps
___ Easy bruising/bleeding

Endocrine

___ Excessive thirst or urination

Other (please specify) _____

I have none of the above problems.