SOCIAL HISTORY SURVEY

Patient Name:_____________________________________         DOB:____________

Caffeine Use:
Do you consume caffeine? □ Yes □ No
If yes, how often? □ Daily □ Occasionally □ Rarely

Alcohol Use:
Do you consume alcoholic beverages? □ Yes □ No
If yes, how often have you had a drink containing alcohol in the past year?
□ Never □ Monthly or less □ 2 to 4 times a month □ 2 to 3 times per week □ 4 or more times a week

Recreational Drug Use:
Do you use recreational drugs? □ Yes □ No
□ Past history of drug use □ Not currently using

Nicotine Use:
Please check all that apply: □ Current smoker □ Former Smoker □ Never Smoked
□ Current smokeless tobacco user □ Current Cigar Smoker □ Current E-Cig user
□ Light tobacco smoker □ Heavy tobacco smoker □ Unknown if ever smoked
If "Former Smoker ": How long ago did you quit?
□ Less than 1 year □ 1-5 years ago □ 5-10 years ago □ More than 10 years ago
If "Current smoker ": How much do you smoke in a week?
□ Less than 1 pack □ 1 to 2 packs □ More than 2 packs

Exercise:
Do you currently exercise? □ Yes □ No □ Unable to exercise
If yes, how often? □ Daily □ On a regular basis □ Occasionally □ Rarely

Flu Vaccine:
Have you had a flu shot since the most recent September 1? □ Yes □ No
Have you had a flu vaccine between October 1 - March 31?
□ Yes □ No Date of last flu shot _________________________

Are you over age 65? □ Yes □ No If yes, please answer the following questions:
Have you ever had a Pneumonia Vaccine? □ Yes □ No Date of last Pneumonia vaccine____________
In the past year, have you fallen 2 or more times? □ Yes □ No