



## 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