



BON SECOURS MEDICAL GROUP
Bon Secours Richmond Health System



Place patient label inside box (if no patient label, complete below)

Name: _____

DOB: _____

MR #: _____

SOCIAL HISTORY

Living Will? Yes No Power of Attorney? Yes No

1. Do you have any allergies? Yes No
If yes, Please specify medication and reaction: _____

2. Name any physician(s) currently attending you. _____

3. List any hospitalization(s) and/or surgeries you have had. _____

4. Immunizations/Tuberculosis
If you have had the following, list year of most recent vaccination:
Tetanus: _____ Flu: _____ Pneumovax: _____
Hepatitis B: _____ Measles: _____ Rubella: _____
If you have been previously skin tested for tuberculosis, year of test: _____
Result: negative (no reaction) positive

5. **To be completed by women:** Do you currently take birth control pills? Yes No
Last menstrual cycle started _____ and ended _____
Average length of cycle? _____ days. Is your menstrual flow normal? Yes No
Number of children _____ Number of pregnancies _____ Number of miscarriages _____

6. Check any of the following problems that apply to you.
- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Acid indigestion or heartburn | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin disease, frequent boils |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Discomfort on moving bowels | <input type="checkbox"/> Inflamed eyes | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Intestinal parasites | <input type="checkbox"/> Stiff joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Back trouble | <input type="checkbox"/> Ear aches | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Stress or anxiety |
| <input type="checkbox"/> Bad teeth or dentures | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Black bowel movements | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Kidney disease/stones | <input type="checkbox"/> Swallowing difficulty |
| <input type="checkbox"/> Blood in bowel movement | <input type="checkbox"/> Fast heart beat | <input type="checkbox"/> Kidney or bladder infection | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Frequency urinating | <input type="checkbox"/> Malaria | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Burning when urinating | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Tightness in chest |
| <input type="checkbox"/> Change in weight | <input type="checkbox"/> Frequent nosebleeds | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Trouble controlling urine |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Trouble getting urine started |
| <input type="checkbox"/> Cocaine or other drug use | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Cold hurts my fingers | <input type="checkbox"/> Hair falling out | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pus, albumin or sugar in urine | <input type="checkbox"/> Vomiting or nausea |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Weakness of an arm or leg |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Weakness or tiredness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Yellow jaundice |

7. Please list any immediate family members who have experienced the following:

Cancer & type:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	
Diabetes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	
Heart disease:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	
Mental illness:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	
High blood pressure:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	
Stroke:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	
Any other serious illness:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member?	

Social History		Marital Status		<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Living		<input type="checkbox"/> Live alone <input type="checkbox"/> Live with significant other <input type="checkbox"/> Live with spouse <input type="checkbox"/> Live with other		
Race: _____ Ethnicity: _____				
Employment		<input type="checkbox"/> Occupation/ Employer → <input type="checkbox"/> Homemaker <input type="checkbox"/> Student (where, major, year) →		
Tobacco				
<input type="checkbox"/> NO - I do not smoke and have never smoked <input type="checkbox"/> YES - I previously smoked but no longer smoke <input type="checkbox"/> YES - I am currently smoking		Quit Date? Previous # of packs per day? Previous # of yrs smoking? Number of packs per day? Number of years smoking?		
Alcohol				
<input type="checkbox"/> NO - I do not drink any alcohol <input type="checkbox"/> YES - I previously drank alcohol but no longer drink alcohol <input type="checkbox"/> YES - I drink alcohol		Quit Date? Type of alcohol? Number of drinks per week? Years drinking?		
<input type="checkbox"/> YES - I drink alcohol Type of alcohol? Number of drinks per week? Years drinking?				
Drugs				
Have you ever given yourself street drugs with a needle? <input type="checkbox"/> Yes <input type="checkbox"/> No		What type of street drugs have you used in the past or are currently using?		
Sexual History				
Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, are you currently trying to become pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If not trying to become pregnant, list contraceptive or barrier method using:		When was your last menstrual period? How many periods do you have per year?		
Military History				
Have you ever been in the military service? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, which branch? <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard <input type="checkbox"/> Reserves <input type="checkbox"/> Other		

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