Patient Lifestyle and Social History Form

Please complete this form to help us understand your daily habits, lifestyle, and social environment. This information is confidential and will be used to provide you with the best possible care.

Patient Identification

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Today's Date:

Tobacco and Nicotine Use

Do you currently use tobacco or nicotine products? (Yes / No / Former):

If yes or former, what type? (Cigarettes, Vape, Chew, Cigar, Pipe):

Quantity per day and number of years used:

If former user, what year did you quit?:

Alcohol and Substance Use

Do you drink alcohol? (Yes / No / Socially):

Average number of drinks per week:

Do you use recreational drugs or substances? (Yes / No / Former):

If yes, please list substances and frequency of use:

Daily caffeine intake (e.g., 2 cups of coffee, 1 soda):

Diet and Physical Activity

Describe your general diet (e.g., Balanced, Vegetarian, Low-carb, High-sodium):

How often do you engage in physical exercise? (e.g., 3 times/week):

What type of exercise or physical activities do you perform?:

Sleep, Stress, and Mental Wellbeing

Average hours of sleep per night:

Current stress level (Low, Moderate, High):

Primary sources of stress (e.g., Work, Family, Finances):

What do you do to manage stress or relax?:

Occupation and Social History

Current Occupation / Employment Status:

Living arrangements (e.g., Alone, With spouse/partner, With roommates, Family):

Do you feel safe and secure in your current home environment? (Yes / No):

Do you have a reliable social support system of family or friends? (Yes / No):

List any hobbies, community activities, or special interests:

Additional Patient Notes

Is there anything else about your lifestyle, culture, or background you would like to share?: