

The Rothfeld Center - PATIENT HISTORY

NAME OF PATIENT _____

DATE ____/____/____

Past Medical and Dental History

(Prior illness, hospitalization, surgery, injury-include vehicle accidents, whiplash and childhood or birthing trauma, include tooth extractions root canals and tooth/jaw injuries)

Item and Reason	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Number of Brothers and Sisters _____

Your Birth Order (1st, last, etc.) _____

Check all that apply	Mother	Father	Grandparent	Sister/Brother	Spouse	Children
AIDS						
Alcoholism						
Allergies						
Alzheimer's						
Arthritis						
Asthma						
Cancer						
Depression						
Diabetes						
Drug abuse						
Heart disease						
High blood pressure						
Stroke						
Thyroid problems						
Tuberculosis						

Social History

Check all that apply

- | | | |
|---------------------------------------|---------------------------------------|---|
| Relationship Status | Education | Memories of your childhood |
| <input type="checkbox"/> Single | <input type="checkbox"/> High school | <input type="checkbox"/> Mostly happy |
| <input type="checkbox"/> Married | <input type="checkbox"/> College | <input type="checkbox"/> Mostly painful |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Prof. school | <input type="checkbox"/> Normal |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Don't recall |

Occupation _____

Living arrangement Alone Family Roommate Other: _____

Children (list ages) _____

Major stresses in last 6 months _____