Single Married Partner Separated Divorced Widowed (year) Children//Grandchildren Occupation:	Last Name	First Name	Age	Referring Provider		Primary Care Provider	
Children/Grandchildren	Social History						
Employment status Occupation: Do you smoke/Vape now? Y N How many packs per day? Did you ever smoke/Vape? Y N What year did you quit? Past Medical History (Please check all items that you have had in the past or are currently being treated for) High Blood Pressure Diabetes Esophageal Reflux Insomnia High Cholesterol Thyroid Disease Nasal Allergies Sleep Apnea Heart Artery Disease Kidney Disease Asthma Restless Legs CHF Chronic Pain Anxlety Parkinson's Vacular Disease Autoimmune Disease Depression Anemia-B12/Iron Varicose Veins Seizures Mono/Meningitis Cancer PRIOR: Heart Attack Stroke / TIA Pancreatitis Head Trauma Mono/Meningitis Cancer Year Nasal Septal Repair Sinus Surgery Palate Surgery Heart Bypass # Heart/Arterial stents # Carotid Surgery Heart Bypass # Heart/Arterial stents # Carotid Surgery Heart Bypass # Hysterectomy / Ovaries Other Piobetes Intyroidectomy Tonsillectomy / Adenoids Prostate Surgery Hysterectomy / Ovaries Other High BP O O Diabetes O Noberter Father Sister Brother Daughter Son Diabetes Hysterectomy / Ovaries O High PP O D Nobesity D	Single Married Partner	Separated	Divorced	Widowed	I	(year)	
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Do you drink alcohol? Y N Type of Alcohol	Did you ever smoke/Vape?	Y N Wha	t year did yo	u quit?			
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Heart Disease Stroke/TIA Kidney Disease Obesity Sleep Apnea Insomnia	High Cholester	ol					
Stroke/TIA Kidney Disease Obesity Image: Sleep Apnea	CHF						
Kidney Disease Obesity Image: Sleep Apnea Insomnia	Heart Disease						
Obesity	Stroke/TIA						
Sleep Apnea	Kidney Disease	<u> </u>					
Insomnia	Obesity						
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