Health and Lifestyle History

PATIENT NAME	DATE OF BIRTH

The following questions help your provider get to know you better so we can work more closely with you to develop a health care plan that will work for you.

With whom do you currently live?
Do you have children?
What is your primary language?
Where were you born?
What level of education did you complete?
Do you have family or friends nearby?
Do you require assistance for basic needs?
Do you follow any special diet?
How much caffeine do you consume per day?
Do you exercise?
Do you sleep well?
Do you have any hobbies?
Do you have any Advanced Directives, a Living Will or Durable Power of Attorney for medical decision making? ☐YES ☐NO

PATIENT/GUARDIAN SIGNATURE	DATE
PSHC PROVIDER SIGNATURE	DATE