



<b>Family History -</b>		<b>Are you adopted?</b>		<b>Yes</b>	<b>NO</b>
Father	Alive	Deceased	Age	Cause of Death	
Mother	Alive	Deceased	Age	Cause of Death	
Please list medical problems of family members. Note especially, arthritis, asthma, cancer (specify type and age of diagnosis) diabetes, emphysema, heart, blood pressure, gastrointestinal, seizures, osteoporosis, stroke, depression, and thyroid problems.					
<b>Relative</b>	<b>Medical Condition</b>			<b>Comments</b>	
<b>Personal Tobacco use</b>					
Never	Exposed to second hand smoke?				
Quit	Quit Date:	How many packs per day?		How many years?	
Current user of (circle)	Cigarettes	Pipe	Cigars	Snuff	Chew
How many, how often?			What age did you start?		
<b>Alcohol</b>					
None	Yes	Type and how many a week.			
Have you had a history of alcohol abuse in the past?					
<b>Drug - Do you use illegal drugs, have you experimented with them in the past?</b>					
NO	Yes	Hx of Use			
Marijuana <input type="checkbox"/>	Cocaine <input type="checkbox"/>	Amphetamines <input type="checkbox"/>	Narcotics <input type="checkbox"/>	Heroin <input type="checkbox"/>	Ecstasy <input type="checkbox"/> Crystal Meth
<b>Sexual Partners:</b>					
Partners	Spouse	Male	Female		
Female: Birth Control use:					
Live Births	Stillbirths	Abortions		Miscarriages	
Are you currently pregnant?					
<b>Other Concerns:</b>					
Have you had any blood transfusions?					
How much caffeine do you consume in a day? (specify type and amount):					
Occupational Exposure:					
Do you have any sleep concerns?					
Do you have any stress concerns?					
Weight Issues					
Do you follow a special diet?					
Describe your exercise regimen.					
Other concerns:					








