



9. **Allergies:** Yes () No () (Ex: Hay fever, foods, medications)
 If yes, what kind: _____

10. **Do you smoke?** Yes () No () **If yes,** how many packs per day? _____
 For how many years? _____
If no, have you ever smoked? _____
 When did you quit? _____
 How many packs per day did you smoke? _____
 For how many years? _____

11. **Alcoholic beverages?** Yes () No () If yes, ounces per day? _____

12. **CURRENT MEDICATIONS: (Use other side if necessary)**

Name	MGS.	HOW MANY?	HOW OFTEN?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. **FAMILY HEALTH HISTORY: (use other side if necessary)**

	AGE	State of Health	Deceased	At Age	Cause of Death
FATHER	_____	_____	()	_____	_____
MOTHER	_____	_____	()	_____	_____
BROTHER	_____	_____	()	_____	_____
"	_____	_____	()	_____	_____
"	_____	_____	()	_____	_____
SISTER	_____	_____	()	_____	_____
"	_____	_____	()	_____	_____
"	_____	_____	()	_____	_____

14. **ILLNESSES-FAMILY OR RELATIVE:**

	Yes ()	No ()	If Yes, who?
a. Diabetes:	Yes ()	No ()	_____
b. Heart Disease under age 50	Yes ()	No ()	_____
c. High Blood Pressure	Yes ()	No ()	_____
d. Cancer	Yes ()	No ()	_____
e. Rheumatoid Arthritis	Yes ()	No ()	_____
f. Gout	Yes ()	No ()	_____
g. Tuberculosis	Yes ()	No ()	_____
h. Mental Illness	Yes ()	No ()	_____
i. Suicide	Yes ()	No ()	_____
j. Alcoholism	Yes ()	No ()	_____

15. **Are there any conditions or illnesses that tend to run in your family?** Yes () No ()

If yes, please explain: _____