Family History

Mother: ____ Living _____Deceased – cause _____ age _____

Father: _____Living _____Deceased – cause _____ age _____

Please check if your parents or siblings have had any of following:

_____Cancer _____Heart Disease _____ Lung Disease

_____Depression _____ High Cholesterol _____ Stroke

_____Diabetes _____ Hypertension

Other_____

Health Prevention/Promotion

Do you smoke? YES NO Packs per day _____

Have you ever smoked in the past? YES NO Packs per day_____ Quit date _____

Do you drink alcohol? YES NO Amount per week_____

Do you drink caffeine? YES NO Cups per day_____

Do you do recreational drugs? YES NO Marijuana_____ Cocaine_____ Ecstasy _____ GHB_____

Crystal Meth_____ Ketamine_____ Other_____

Do you wear glasses/contacts? YES NO

Do you wear a hearing aid? YES NO

Do you wear dentures? YES NO

Do you have a Living Will? YES NO (please provide office with a copy if possibly)