





Family History:

<b>Disease</b>	<b>Family Member</b> ( <i>Mother, Father, Grandparent, Etc</i> )
Diabetes	_____
Hypertension	_____
Heart Disease	_____
Mental Illness	_____
Cancer	_____
Seizures	_____
Epilepsy	_____
Parkinson's	_____
Alzheimer's	_____
MS	_____
Neuropathy	_____
ALS	_____
Other:	_____

Social History:

- Are you a **current smoker** \_ **former smoker** \_ **nonsmoker** \_
  - If so, how many cigarettes a day? \_\_\_\_\_
  - Have you considered quitting? **Yes / No / Thinking about it**
  - If former how long has it been since you last smoked? \_\_\_\_\_
- Do you use any other type of Tobacco? Yes \_ No \_ What type? \_\_\_\_\_
- Do you use any recreational drugs? Yes \_ No \_ If so, which drugs? \_\_\_\_\_
- Did you have a drink containing alcohol in the past year? Yes \_ No \_
- If Yes, how often did you have a drink containing alcohol in the past year?
  - **Monthly or less**   **2-4 times a month**   **2-3 times a week**   **4+ times a week**
- How many drinks did you have on a typical day when you were drinking in the past year?
  - **1-2 drinks**   **3-4 drinks**   **5-6 drinks**   **7-9 drinks**   **10 or more drinks**
- How often did you have 6 or more drinks on one occasion in the past year?
  - **Never**   **Less than monthly**   **Monthly**   **Weekly**   **Daily or almost daily**
- Do you drink any beverages containing caffeine? (*Coffee, tea, soda, etc*) Yes \_ No \_
- If yes, how many cups per day? **1-2 cups** \_ **2-3 cups** \_ **3-4 cups** \_ **More than 4**

