



Allergies to medications	
Name the Drug	Reaction You Had
Other Allergies (food, environmental, etc)	

**HEALTH HABITS AND PERSONAL SAFETY**

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.					
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day?				
<b>Alcohol</b>	Do you drink alcohol?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Beer	<input type="checkbox"/> Wine	<input type="checkbox"/> Hard Alcohol	What best describes your drinking: social <input type="checkbox"/> occasional <input type="checkbox"/> Light <input type="checkbox"/> heavy <input type="checkbox"/>	
<b>Tobacco</b>	Do you use tobacco?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Dipping – #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			
<b>Drugs</b>	Have you ever used any illegal or street drugs?		<input type="checkbox"/> Never Used	<input type="checkbox"/> Current User	<input type="checkbox"/> Previous User
FAMILY HEALTH HISTORY					

ARE YOU ADOPTED?  YES  NO

ONLY SIGNIFICANT HEALTH PROBLEMS						
FAMILY MEMBER		LIST HEALTH PROBLEM:	FAMILY MEMBER		LIST HEALTH PROBLEM:	
<b>Father</b>	<input type="checkbox"/> Alive		<b>Children</b>	<input type="checkbox"/> M		
	<input type="checkbox"/> Deceased			<input type="checkbox"/> F		
<b>Mother</b>	<input type="checkbox"/> Alive			<input type="checkbox"/> M		
	<input type="checkbox"/> Deceased		<input type="checkbox"/> F			
<b>Sibling</b>	<input type="checkbox"/> M		<input type="checkbox"/> M			
	<input type="checkbox"/> F		<input type="checkbox"/> F			
	<input type="checkbox"/> M		<b>Grandmother</b> <i>Maternal</i>		<input type="checkbox"/> Alive	
	<input type="checkbox"/> F				<input type="checkbox"/> Deceased	
	<input type="checkbox"/> M		<b>Grandmother</b> <i>Paternal</i>		<input type="checkbox"/> Alive	
	<input type="checkbox"/> F				<input type="checkbox"/> Deceased	
<input type="checkbox"/> M	<b>Grandfather</b> <i>Maternal</i>	<input type="checkbox"/> Alive				
<input type="checkbox"/> F		<input type="checkbox"/> Deceased				
<input type="checkbox"/> M	<b>Grandfather</b> <i>Paternal</i>	<input type="checkbox"/> Alive				
<input type="checkbox"/> F		<input type="checkbox"/> Deceased				

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_