FAMILY MEMBERS:

	Living				Deceased	
	Age	Health			Age at Death	Cause of Death
		Good	Fair	Poor		
Father						
Mother						
Brother(s)						
Sister(s)						

Tobacco Use: [ ] No [ ] Yes [ ] Former Packs/Day_____ How Long _____yrs Date Quit _____

Alcohol Use: [ ] No [ ] Yes Beers/Day _____ Hard Liquor Drinks/Day _____

Former Alcohol Use: How many years? _____ Date Quit _____

Do you drink coffee? No Yes How many per day?

HOSPITALIZATIONS/REASONS: **DATE(S)**

_____

_____

_____

Do you wear artificial devices? Yes No

Please list _____

_____

IMMUNIZATIONS:

	Yes	No	Date
Pneumonia			
Tetanus			
Booster			
Measles			
Influenza			
German Measles/Mumps			
Other (specify)			

X-RAYS:

	Yes	No	Date
When was your last mammogram?			
Back			
Chest			
Colon			
Extremities			
Gall Bladder			
Kidney			
Stomach			
Treatments			
Other (specify)			

Name_____DOB _____