Name:_____ DOB:_____

FAMILY HISTORY

RELATIONSHIP	MEDICAL CONDITION(S)	LIVING/DECEASED
Mother		
Father		
Sibling (brother/sister)		
Sibling (brother/sister)		
Sibling (brother/sister)		
Sibling (brother/sister)		
Daughter/Son		
Daughter/Son		
Daughter/Son		
Daughter/Son		

Do you have a family history of autoimmune diseases, osteoporosis or blood disorders? Please list:

_____

SOCIAL HISTORY

Single Married Life partner Divorced Widowed

Level of Education: _____ **Number of Children:** _____

Do you smoke? Yes No **If Yes, how long?** _____

Please circle number of packs you smoke per day: 0 ½ 1 1 ½ 2 2 ½ 3 More than 3

Do you have a history of smoking? Yes No **When did you quit?** _____

Do you use smokeless tobacco (chewing tobacco/Skoal)? Yes No

Do you drink alcohol? Yes No How much? _____ **How often?** _____

Are you currently using or have you ever used illicit drugs? Yes No

OCCUPATIONAL HISTORY

Are you currently working? Yes No

What is your work status now? Full Time Part Time Laid Off Retired Disabled

Occupation: _____