

Yes No Do you take any prescription, over-the-counter medication, or herbal therapies regularly or occasionally (including aspirin, Advil, vitamins, etc?) _____

Yes No Are you allergic to any medication? If yes, please list and explain what happened.

Yes No Do you smoke? If yes, number of packs per day _____ for how long _____

Yes No Do you drink any alcoholic beverages? Number of drinks per day _____

Yes No Have you ever had a positive blood test for HIV?

List all operations you have had:

Operation Year Doctor City, State

To the best of your knowledge, have YOU or ANY *members of your family* ever had problems with any of the following:
(Please explain all yes answers)

			Myself	Family Member
Yes	No	Eyes/Ears/Nose		
Yes	No	Mouth/Throat		
Yes	No	Cardiovascular		
Yes	No	Respiratory		
Yes	No	Gastrointestinal		
Yes	No	Genital/Urinary		
Yes	No	Musculoskeletal		
Yes	No	Skin/Breast		
Yes	No	Neurological		
Yes	No	Psychiatric		
Yes	No	Endocrine		
Yes	No	Hematologic/Lymphatic		
Yes	No	Allergic/Immunologic		