

FAMILY HISTORY

Are you adopted? Yes No

List the cause of death for those who have died **prior to age 50** (Do not include accidental deaths)

Father _____ Mother's Father _____ Father's Father _____

Mother _____ Mother's Mother _____ Father's Mother _____

List any blood relatives that have the following illnesses/diseases.

- | | | | |
|--|-------|---|-------|
| <input type="checkbox"/> Alcoholism | _____ | <input type="checkbox"/> Mental Illness | _____ |
| <input type="checkbox"/> Alzheimer's/Dementia | _____ | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Cancer (Breast) | _____ | <input type="checkbox"/> Heart Attack prior to age 55 | _____ |
| <input type="checkbox"/> Cancer (Colon) | _____ | <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Cancer (Prostate) | _____ | <input type="checkbox"/> High Cholesterol | _____ |
| <input type="checkbox"/> Cancer (Lung) | _____ | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Cancer _____ | _____ | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Diabetes (type _____) | _____ | <input type="checkbox"/> Substance Abuse | _____ |
| <input type="checkbox"/> Emotional Illness | _____ | <input type="checkbox"/> Thyroid Disease | _____ |

SOCIAL HISTORY

1. Grade in School: _____

2. Your sex: Female Male

3. Race: Caucasian Hispanic Indian African American Asian Polynesian/Island Other: _____

4. Religious Preference: LDS Catholic Baptist Jewish Protestant N/A Other: _____

5. What is your smoking status? Non-Smoker Past Current

6. How many alcoholic drinks do you consume in one day? Non-Drinker 1 – 2 3 or more

7. Do you follow a special diet? Gluten Free Low Fat /Calorie Vegetarian Other: _____

8. Do you need help for a problem related to physical, verbal, or mental abuse? Yes No