Patient Name:____ Date of Birth:_______________________

Circle one:

Single Married Partnered Divorced Widowed

Number of Children:
Number of Pregnancies:

Are you a smoker? Yes No
If yes, how many packs per day?
Year that you quit:

Do you exercise on a regular basis? Yes No
How many days a week?

Do you consume alcoholic beverages? Yes No
Circle one: Daily Weekly Occasionally Never

Do you use street drugs? Yes No
If yes, please list type:___________________
Circle one: Daily Weekly Occasionally Never

Do you use medical marijuana? Yes No

Do you consume caffeine on a daily basis? Yes No
If yes, how many caffeinated beverages per day?

Do you wear your seat belt? Yes No

Do you work outside the home? Yes No
What kind of work do you do?