How old is your home? _____ How many years have you lived there? _____

Use of Alcohol: ☐ Never ☐ On Occasion ☐ Moderately ☐ Daily

Use of Tobacco: ☐ Never ☐ On Occasion ☐ Moderately ☐ Daily

When started: _____ Number of Packs per day _____ If quit, when _____

Use of Drugs: ☐ Never ☐ On Occasion ☐ Moderately ☐ Daily

Type: _____ Frequency _____

Known Toxic Exposures: _____

_____

_____

Past Surgeries:

Surgery			Date	Surgery			Date
Tonsillectomy	☐ Yes	☐ No		Hernia	☐ Yes	☐ No	
Appendectomy	☐ Yes	☐ No		Root Canal	☐ Yes	☐ No	
Gall Bladder	☐ Yes	☐ No		Hysterectomy	☐ Yes	☐ No	

Please list additional surgeries with approximate dates:

Surgery	Date	Surgery	Date

Please list past accidents or physical injuries:

Injury	Date	Injury	Date

Please list any Family history of serious illnesses:

Illness	Relationship	Illness	Relationship

What can we do to make you happier? _____

Signature _____ Date _____