Please complete the following questionnaire as completely as possible. Thank you.

Name: _____ Age: _____

Occupation: _____

Highest level of education: _____

Place of birth: _____

Who lives with you? _____

Do you smoke cigarettes? If **yes**, how much? _____

Do you drink alcohol regularly? If **yes**, how often and how much?

Do you exercise? If **yes**, what kind, how often, and for what period of time per session:

Are you sexually active? If **yes**, what kind of birth control method:

Do you wear a seatbelt at all times while traveling in a car?

Have you ever been hospitalized or had any surgeries? If **yes**, please list:

Do you have any major medical problems? If **yes**, please list:

_____

_____

When was your last tetanus shot? _____

Do you take any medications? If **yes**, please list:

_____

_____

Do you have any allergies to medication? If **yes**, please list:

_____

_____

Is there a family history of:

1) Diabetes?	Y/N
2) Stroke?	Y/N
3) Heart attack?	Y/N
4) High blood pressure?	Y/N
5) Cancer?	Y/N
6) Tuberculosis?	Y/N

Age of father: _____ Health condition: _____

Age of mother: _____ Health condition: _____

Age of brothers: _____ Health condition: _____

Age of sisters: _____ Health condition: _____

Age of spouse: _____ Health condition: _____

Age of children: _____ Health condition: _____