

ALLERGIES: Please list your allergies, if any, below.

Allergy	Reaction

FAMILY HISTORY: Are there any diseases that run in your family?

Family Member	Medical Condition

VACCINATIONS:

What year was your last tetanus shot? _____

Have you ever received the pneumonia shot? _____

SOCIAL HISTORY:

Have you ever used tobacco? _____

Do you drink alcohol? _____

Have you ever used recreational drugs? _____