

Please list all medicines, doses, and times you take them.

Do you smoke now? Yes No If you quit, when _____

Do you smoke: cigarettes pipe cigars How many per day? _____

When did you start? (age) _____

Do you drink coffee? Yes No More than three cups per day? Yes No

Do you drink more than 12 oz. beer, 6 oz. wine, 3 oz. whiskey per day? Yes No Have you ever? Yes No

Do you take vitamins? Yes No Which? _____

Do you use more than four aspirin per week? Yes No

Do you use over the counter medicines (nasal sprays, decongestants, allergy pills, etc.) REGULARLY / DAILY? Yes No

Have you ever had (check) Hepatitis Mononucleosis EB Virus Malaria Anemia (Check here if none:)

Have you ever been told you had a heart murmur? Yes No