**NAME:** **Height:** **Weight:**

**PLEASE WRITE LEGIBLY!**

**Allergies to medications:**

**On any medication (if so, please list):**

**Medical Conditions: (asthma, diabetes, high blood pressure, HIV/AIDS, etc.):**

**Past Surgeries (please list dates):**

**Family Medical Conditions (if deceased, please state age):**

**Father:**

**Mother:**

**Brother:**

**Sister:**

**Are you currently a smoker: YES / NO** **If "Y", how much:____per day/ years used: _____**

**Do you currently chew tobacco: YES / NO**

**Drink alcohol: NONE / OCCASIONAL / MODERATE / HEAVY**

**Caffeine Intake: NONE / OCCASIONAL / MODERATE / HEAVY**

**Illicit drugs:**