Do you know of any blood relative who has or had: (Circle and give relationship)

☐ Stroke _____	☐ Epilepsy _____	☐ Heart Attack _____	☐ Colitis _____
☐ Cancer _____	☐ Suicide _____	☐ Stomach Ulcers _____	☐ Nervous Breakdown _____
☐ High Blood Pressure _____	☐ Migraine _____	☐ Kidney Disease _____	☐ Rheumatic Heart _____
☐ Tuberculosis _____	☐ Asthma _____	☐ Goiter _____	☐ Insanity _____
☐ Diabetes _____	☐ Hay Fever _____	☐ Arthritis _____	☐ Congenital Heart _____
☐ Leukemia _____	☐ Bleeding Tendency _____		

PERSONAL HABITS: (Circle)

Yes No Do you regularly smoke? Cigarettes ☐ Pipe ☐ Cigars ☐ For how many years? _____

Yes No Do you usually drink over 6 cups of coffee per day?

Yes No Do you regularly drink alcohol? 1 oz. per day ☐ 2 oz. per day ☐ 4 oz. per day ☐ over 6 oz. ☐

BEER: 1 bottle per day ☐ 2 bottles per day ☐ over 4 bottles per day ☐

Yes No Do you have difficulty in falling asleep?

Yes No Do you awaken early in the morning without apparent cause?

MEDICATIONS:

Are you presently taking any of the following medications? (Circle)

Yes	No	Aspirin, bufferin, anacin	Yes	No	Tranquilizers
Yes	No	Blood pressure pills	Yes	No	Weight reducing pills
Yes	No	Cortisone	Yes	No	Blood thinning pills
Yes	No	Cough medicine	Yes	No	Dilantin
Yes	No	Digitalis	Yes	No	Shots
Yes	No	Hormones	Yes	No	Water pills
Yes	No	Insulin or diabetic pills	Yes	No	Antibiotics
Yes	No	Iron or poor blood medications	Yes	No	Barbituates
Yes	No	Laxatives	Yes	No	Birth control pills
Yes	No	Sleeping pills	Yes	No	Phenobarbital
Yes	No	Thyroid medicine	Yes	No	Other drugs not listed

Write in the names and year of any operations which you have had:

_____

_____

_____

Name any drugs to which you are allergic:

_____

_____

_____

Write in the names of any diseases you have had which required hospitalization:

_____

_____

_____

_____

_____

_____