





Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
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Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____



Seasonal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<b>Smoking</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How much? _____		If stopped, how long ago? _____
<b>Alcohol</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How much? _____		If stopped, how long ago? _____
<b>Substance abuse</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How much? _____		If stopped, how long ago? _____
<b>Do you exercise regularly?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Are you on a special diet?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

What kind? \_\_\_\_\_

<b>Do you need any special assistance?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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What kind? \_\_\_\_\_

**LIVING WILL**  
 Please provide a copy, if possible  Yes  No

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