ALCOHOL

Do You Drink Alcohol? ☐YES ☐NO

If yes, please indicate the following

Hard Liquor ☐YES ☐NO
☐1 oz ☐2 oz ☐3 oz
☐Daily ☐Weekly ☐Monthly

Beer ☐YES ☐NO
☐1-2 Beverages ☐3-4 Beverages
☐5-6 Beverages ☐7 + Beverages
☐Daily ☐Weekly ☐Monthly

Wine ☐YES ☐NO
☐1-2 Beverages ☐3-4 Beverages
☐5-6 Beverages ☐7 + Beverages
☐Daily ☐Weekly ☐Monthly

Do You Drink Coffee? ☐YES ☐NO

Please indicate the following:

☐Caffeinated ☐Decaffeinated

# of Cups / Day _____

Do you use recreational drugs? ☐YES ☐NO

If yes, please indicate the following:

Marijuana? ☐YES ☐NO
If yes, how often? ☐Daily ☐Weekly ☐Monthly

Cocaine? ☐YES ☐NO
If yes, how often? ☐Daily ☐Weekly ☐Monthly

IV drugs? ☐YES ☐NO
If yes, how often? ☐Daily ☐Weekly ☐Monthly

Other? ☐YES ☐NO
If yes, how often? ☐Daily ☐Weekly ☐Monthly

Do you drink soda? ☐YES ☐NO
If yes, indicate:
Brand _____
How Much _____

Do you use Tobacco ☐YES ☐NO
If yes, please indicate the following:

☐Cigarettes ☐Cigars ☐Pipe ☐Smokeless Tobacco

# of packs per day: _____

Number of years: _____

Have you stopped using tobacco? ☐YES ☐NO

If yes, when? _____

Have you visited outside the US in the last 6 months? ☐YES ☐NO

If yes, where? _____

Have you visited any farms recently? ☐YES ☐NO

If yes,, please indicate the following: _____

What kind? _____

When? _____

Please indicate the conditions that have been diagnosed, the year of the diagnosis and by whom. If you have a doctor's address, please include it.

Condition	YEAR	BY WHOM