

III. LIFESTYLE HISTORY

a. Have you ever been pregnant? YES NO N/A

If Yes, How many births? Cesarean Birth? YES NO

Were there any complications? YES NO

What were the complications?

b. Current Smoker?

YES NO

if yes, How long?

ex - Smoker?

YES NO

if yes, How long?

When you quit



c. Do you drink alcohol?

YES NO

if yes, How much?

How often?

d. Do you take any street or recreational drugs? YES NO

e. Do you currently take medications?

YES NO

What are the medications?

f. Herbal or Dietary Supplements?

YES NO

What are the supplements?

g. Number of meals per day:

number of "fast food" meals per week?

h. Exercise Regularly? YES NO

how long?

how often?

i. Are you employed or self employed?

YES

NO

j. Have you had any work related illness or injuries?

YES

NO