8. Family History - (circle which applies)

   Father: living or deceased? Mother: living or deceased?

   Brother: living or deceased? Sister: living or deceased?

9. Between Father, Mother, Brother and Sister is there a history of:

   Cancer? Who: _____ Kidney Disease? Who: _____

   Heart Disease? Who: _____ Hypertension? Who: _____

   Diabetes? Who: _____ Stroke? Who: _____

   Lung Disease? Who: _____ Foot problems? Who: _____

10. Do you work? Works, does not work, is retired - (circle which applies)

11. Sports? Yes or no? (circle which applies) If yes, what sport? _____

12. (Circle which applies) Have you had any recent unexplained: weight gain or loss, fever, chills, fatigue, muscle pain or weakness.

13. Ethnicity: Are you Hispanic or Latino? Yes or No (circle which applies).

14. Language spoken: _____

15. Race: White, Black or Asian - (circle which applies). If none applies fill in : _____

16. Smoker (circle which applies): current, former, never.

17. Pharmacy (name and street it is on with zip code if they know it):

    _____

18. Primary Care Provider Name (first and last):

    _____

    Last Visit: _____

Height: _____ Weight: _____ Shoe Size: _____

Signature: _____ Date: _____