Name: _____

Address: _____

_____

Occupation: _____

General practitioner: _____

Have any of the following illnesses occurred in your family:

□ Stroke
□ Diabetes
□ Cardiac infarction
□ Cancer
□ Epilepsy
□ Depression
□ Schizophrenia

Have you had any of these illnesses or surgeries?

□ Stroke
□ Diabetes
□ Cardiac infarction
□ Cancer
□ Epilepsy
□ Depression
□ Schizophrenia

□ Migraine
□ Slipped disc
□ Malfunction of the thyroid gland
□ Other?

Do you drink alcohol?

□ Never
□ Seldom
□ Sometimes
□ Regularly
□ Daily

Do you take medication?

□ Yes
□ No

Do you smoke?

□ No
□ Sometimes
□ 1-5 cig. a day
□ 10-15 cig. A day
□ More

Do you take drugs?

□ Yes
□ No

Do you suffer from allergies?

□ Yes
□ No

Do you suffer from sleep disorder?

□ Yes
□ No

What is your civil status?

□ Single
□ Married
□ Divorced
□ Widowed

Name and dose	Morning	Midday	Evening