Family History: Please list any chronic medical problems in your family (Parents, Siblings):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Social History (ages 12+):

Tobacco: Please answer yes/no or circle the appropriate answer

Do you currently or have you ever smoked?

Tobacco usage: Cigarettes Chewing Cigars Pipe Smokeless Snuff

How much do you/have you in the past smoke/chew per day?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you/did you smoke?:\_\_\_\_\_\_ years

How old were you when you started?:\_\_\_\_\_\_\_\_\_

How old were you when you Quit?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol:

Do you drink alcohol?: Yes No

Type (beer, wine, liquor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often (circle one): Daily Weekly Monthly Occasionally Socially

Caffeine:

Do you drink caffeine (coffee, tea, soda): Yes No

Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount per day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social History (Children- 0-18 yrs only):

Child lives with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any smokers at home: Yes No If yes, inside or outside:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any pets at home: Yes No

**Have you ever had the pneumonia vaccine?** Yes No