

	<u>Never</u>	<u>Occas.</u>	<u>Freq.</u>
1. HEAD AND NECK			
Experience headaches	_____	_____	_____
Experience neck pain	_____	_____	_____
2. MOUTH			
Has teeth problem	_____	_____	_____
Gum, jaw or mouth problem	_____	_____	_____
Tongue or taste sense problem	_____	_____	_____
3. EYES - TROUBLE			
YES _____ NO _____			
Wears eyeglasses	YES _____ NO _____		
Wears contacts	YES _____ NO _____		
Vision changed in last year	YES _____ NO _____		
Eye pressure (Tonometry)	YES _____ NO _____		
Double Vision	_____	_____	_____
Blurred vision	_____	_____	_____
Watery / itchy eyes	_____	_____	_____
Sees halos	_____	_____	_____
4. EARS - TROUBLE			
YES _____ NO _____			
Hearing problem	_____	_____	_____
Wax in ears	_____	_____	_____
Discharge from ears	_____	_____	_____
Loses balance	_____	_____	_____
Dizzy / motion sickness	_____	_____	_____
Ringing in ears	_____	_____	_____
5. NOSE / THROAT TROUBLE			
YES _____ NO _____			
Head colds	_____	_____	_____
Runny nose	_____	_____	_____
Head congestion	_____	_____	_____
Sore / hoarse throat	_____	_____	_____
Sneezing spells	_____	_____	_____
Nose bleeds	_____	_____	_____
6. RESPIRATORY/ LUNG TROUBLE			
YES _____ NO _____			
Chest colds	_____	_____	_____
Coughing spells	_____	_____	_____
Trouble breathing	_____	_____	_____
Cough blood	_____	_____	_____
Chronic cough	_____	_____	_____
Wheezing/asthma/bronchitis	_____	_____	_____
Chest Pain	_____	_____	_____
Hyperventilation	_____	_____	_____
Fainting	_____	_____	_____
7. CARDIOVASCULAR			
Heart trouble	YES _____ NO _____		
Hypertension	YES _____ NO _____		
Out of breath quickly when exercising....	_____	_____	_____
Chest/shoulder pains w/exercise	_____	_____	_____
Breathing problems w/sleep	_____	_____	_____
Sits up at night to breathe easier....	_____	_____	_____
Restless sleeper	_____	_____	_____
Leg cramps at night	_____	_____	_____
Swollen ankles/ feet	_____	_____	_____
Rapid or Irreg. Heartbeat	_____	_____	_____
Dizziness/Fainting	_____	_____	_____
Pain in legs while walking	_____	_____	_____
Electrocardiogram	YES _____ NO _____	DATE _____	
Physically handicapped/limited	YES _____ NO _____		

	<u>Never</u>	<u>Occas.</u>	<u>Freq.</u>
8. MUSCULOSKELETAL			
Shoulder pain	_____	_____	_____
Severe back pain	_____	_____	_____
Muscle/Joint prob. W/exercise	_____	_____	_____
Joint problems not due to exercise	_____	_____	_____
9. DIGESTIVE			
Stomach trouble	YES _____ NO _____		
Stomach nauseated	_____	_____	_____
Stomach pains	_____	_____	_____
Burps after eating	_____	_____	_____
Heartburn	_____	_____	_____
Trouble swallowing food	_____	_____	_____
Vomiting blood	_____	_____	_____
Bowel problem	_____	_____	_____
Bowels constipated	_____	_____	_____
Diarrhea	_____	_____	_____
Painful bowel movements	_____	_____	_____
Bloody bowel movements	_____	_____	_____
Dark bowel movements	_____	_____	_____
Stool test for blood	YES _____ NO _____		
Sigmoidoscopy	YES _____ NO _____		
10. URINARY			
Kidney or bladder problem	_____	_____	_____
Hard to start urine flow	_____	_____	_____
Painful urination	_____	_____	_____
Frequency while awake	_____	_____	_____
Frequency while asleep	_____	_____	_____
Urine dark color, or bloody	_____	_____	_____
Loss urine: strain, laugh cough, sneeze....	_____	_____	_____
Loss urine: sleep	_____	_____	_____
Urinalysis	YES _____ NO _____	DATE _____	
11. MENSTRUATION			
Age menstruation started	_____		
Date last start of menstruation	_____		
Length of last period	_____		
Length of menstrual cycle	_____		
Irregular periods	yes _____ no _____	pads or _____ tampons	
Number of pads or tampons used on heaviest day	_____		
	<u>Occasionally</u>	<u>Frequently</u>	
Menstrual problem	_____	_____	
Premenstrual tension	_____	_____	
Heavy menstrual bleeding	_____	_____	
Painful menstruation	_____	_____	
Bleeds between periods	_____	_____	
Tender breasts	_____	_____	
Discharge from nipples	Yes _____ No _____		
Monthly bras examination	Yes _____ No _____		
Had mammogram	Yes _____ No _____	Date _____	
Breast fed babies	Yes _____ No _____		
Vaginal discharge, burning or itching	Yes _____ No _____		
Date of last Pap Smear	_____		
Has question about V.D.	Yes _____ No _____		
Has hot flashes	Yes _____ No _____		
12. Skin Problems			
Dry skin /brittle fingernails	Yes _____ No _____		
Bruise easily / cuts hard to heal	Yes _____ No _____		
Mole Change	Yes _____ No _____		
Herpes simplex	Yes _____ No _____		

Faintness/Weakness Yes ___ No ___
 Numbness?Paralysis Yes ___ No ___
 Convulsions Yes ___ No ___
 Tremors Yes ___ No ___
 Coordination Problems Yes ___ No ___

Brief description of your current living conditions: _____

YOUR PAST HISTORY OF MEDICAL PROBLEMS, ILLNESSES, INJURIES, SURGERIES AND HOSPITALIZATIONS

Please mark with an (X) any of the following illnesses and medical problems you have or have had and indicate the year when each started. If you are not certain when an illness started, write down an approximate year.

ILLNESS	(X)	Year	ILLNESS	(X)	Year	Illness	(x)	Year
Eye or eye lid infection	___	___	Stomach/duodenal ulcer	___	___	Anemia	___	___
Glaucoma	___	___	Diverticulosis	___	___	Bleeding tendency	___	___
Cataracts	___	___	Colitis	___	___	Blood transfusion	___	___
Other eye problems	___	___	Other bowel problem	___	___	Diabetes	___	___
Ear trouble	___	___	Hepatitis	___	___	Endocrine glandular trouble	___	___
Deafness	___	___	Liver trouble	___	___	Measles/Rubeolla	___	___
Thyroid trouble	___	___	Gallbladder trouble	___	___	German measles/Rubella	___	___
Strep throat	___	___	Hernia	___	___	Polio	___	___
Bronchitis	___	___	Hemorrhoids	___	___	Mumps	___	___
Emphysema	___	___	Kidney or bladder disease	___	___	Scarlet fever	___	___
Pneumonia	___	___	Prostate problem	___	___	Chicken pox	___	___
Allergies	___	___	Mental problems	___	___	Mononucleosis	___	___
Asthma	___	___	Nervous breakdown	___	___	Malaria	___	___
Tuberculosis	___	___	Headaches	___	___	Other tropical diseases	___	___
Other lung problems	___	___	Head injury	___	___	Veneral disease	___	___
High blood pressure	___	___	Stroke	___	___	Genital herpes	___	___
Heart attack	___	___	Convulsions, seizures	___	___	AIDS	___	___
Arteriosclerosis (hardening of the arteries)	___	___	Arthritis	___	___	Other	___	___
Heart murmur	___	___	Eczema	___	___	explain on extra page and attach	___	___
Other heart condition	___	___	Psoriasis	___	___			
High cholesterol	___	___	Gout	___	___			
			Cancer or tumor	___	___			

PLEASE LIST ALL THE TIME YOU HAVE BEEN HOSPITALIZED, OPERATED ON, OR SERIOUSLY INJURED

YEAR	OPERATION, ILLNESS OR INJURY	HOSPITAL AND CITY

RECENT DIAGNOSTIC TESTS

When was your last chest x-ray? Date _____ Results _____
 When did you last have any Lab tests? Date _____ Type _____ Result _____ Type _____ Result _____

YOUR FAMILY'S HEALTH HISTORY

Please give the following information about your immediate family:

Relationship	Age, if living	Age at Death	State of Health or Cause of Death
Father	___	___	___
Mother	___	___	___
Brothers	___	___	___
Sisters	___	___	___
Spouse	___	___	___
Children	___	___	___

Have any blood relatives had any of the following illnesses? If so, indicate relationship.

ILLNESS	FAMILY MEMBER	ILLNESS	FAMILY MEMBER
High blood pressure	___	Depression	___
Heart disease	___	Alcoholism	___
Stroke	___	Suicide	___
		Cancer	___
		Diabetes	___
		Asthma/Emphysema/Bronchitis	___
		Migraine Headaches	___
		Tuberculosis	___
		Cystic Fibrosis	___
		Blood Disease	___
		Glaucoma	___
		Epilepsy	___
		Rheumatoid Arthritis	___
		Gout	___
		Peptic ulcer	___
		Gallbladder disease	___
		Colitis/Irritable bowel	___
		Mental Problems	___
		Multiple Sclerosis	___

Have you recently had any changes in your: If yes, please explain.

Marital status? No ___ Yes ___

Job or work? No ___ Yes ___

Residence? No ___ Yes ___

Financial Status? No ___ Yes ___

Are you having any legal problems
or trouble with the law? No ___ Yes ___

DO YOU:	Never	Occasionally	Frequently
Feel nervous?	___	___	___
Feel depressed?	___	___	___
Find it hard to make decisions?	___	___	___
Tire easily?	___	___	___
Lose your temper?	___	___	___
Worry a lot?	___	___	___
Have trouble relaxing?	___	___	___
Having any sexual problems?	___	___	___
Ever feel like committing suicide?	___	___	___
Feel bored with your life?	___	___	___

DO YOU FEEL:	Never	Occasionally	Frequently
Occupationally satisfied?	___	___	___
Financially satisfied?	___	___	___
Sexually satisfied?	___	___	___
Recreationally satisfied?	___	___	___
Your life is too crowded or too overcommitted?	___	___	___
Hurried or pushed for time?	___	___	___
A vague sense of anger?	___	___	___
Relaxed and contented?	___	___	___
Anxious or frightened?	___	___	___
Do you want to talk to the doctor about a personal matter? Yes ___ No ___	___	___	___

How is your overall health now?.....Poor ___ Fair ___ Good ___ Excellent ___

How has it been most of your life?.....Poor ___ Fair ___ Good ___ Excellent ___

In the past year: Has your appetite changed?.....Decreased ___ Increased ___ Stayed the same ___

Has your weight changed?.....Lost ___ lbs. Gained ___ lbs. Stayed the same ___

Are you thirsty much of the time? Yes ___ No ___

Has your overall "PEP" changed?.....Decreased ___ Increased ___ Stayed the same ___

Have you had a fever that lasted more than one day?.....Yes ___ No ___

Have you had chills or sweat at night?.....Yes ___ No ___

Have you had any lumps in your neck, armpits or groin? Yes ___ No ___

Do you usually have trouble sleeping?.....Yes ___ No ___

How much do you exercise?.....Little or none ___ Less than I need ___ All I need ___

How much coffee or tea do you usually drink?.....cups or coffee or tea per day.

Do you smoke?.....Yes ___ No ___ If yes, how many years? ___

How many each day?.....cigarettes ___ Cigars ___ Pipesfull

Do you drink alcoholic beverages?.....Yes ___ No ___ I drink _____ (type and amount per day)

HAVE YOU EVER:

Had a problem with alcohol?.....Yes ___ No ___ Used marijuana?.....Yes ___ No ___

Had a problem with drugs?.....Yes ___ No ___ Used "hard drugs".....Yes ___ No ___

OCCUPATIONAL/ENVIRONMENTAL

Have you ever worked or spent time:

On a farm? Yes ___ No ___ With or near toxic chemicals? Yes ___ No ___

in a mine? Yes ___ No ___ With or near radioactive materials? Yes ___ No ___

in a laundry or mill? Yes ___ No ___ With or near asbestos? Yes ___ No ___

in a very dusty place? Yes ___ No ___ Near loud machinery? Yes ___ No ___

Do you regularly wear seatbelts? Yes ___ No ___

CURRENT NUTRITION AND DIET

1. How many meals do you eat each day? _____

2. Do you diet frequently and / or are you now dieting? Yes ___ No ___

3. Do you consider yourself: ___ Underweight ___ Overweight ___ Just right

4. Do you add salt to your food at the table? ___ Almost always ___ Sometimes ___ Rarely

List any food supplements or vitamins you take regularly. _____

5. Do you usually eat breakfast? Yes ___ No ___

6. Do you snack? Yes ___ No ___

7. Do you eat a balanced diet? Yes ___ No ___