

INTERNAL MEDICINE WEST INTERVAL HEALTH QUESTIONNAIRE - MALE

Name _____
 Address _____

Today's Date _____
 Date of Birth _____
 Marital Status M - S - D - W

CURRENT CONDITIONS

CURRENT MEDICAL PROBLEMS, CHIEF COMPLAINTS AND PRESENT ILLNESSES

Please list the medical problems for which you came to see the doctor. About when did they begin?

Problem

Date Began

For additional patient explanation or details about current medical problems use additional sheet of paper
 And attach to this form.

Doctors Notes on present illness:

CURRENT MEDICATIONS

Please list all medications you are now taking, including those you buy without a doctor's prescription.
 Such as aspirin, cold tablets or vitamin supplements. List name, dosage, and times per day.

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

CURRENT ALLERGIES, SENSITIVITIES AND INTOLERANCES

List anything that you are allergic to, such as certain foods, medications, dust, chemicals, soaps, household items, pollens,
 bee stings, etc. And indicate how each affects you. Use extra page if more space is needed and attach to this form.

- | | | | |
|---------------------|----------------|---------------------|----------------|
| <u>Allergic To:</u> | <u>Effect:</u> | <u>Allergic To:</u> | <u>Effect:</u> |
| 1. _____ | _____ | 3. _____ | _____ |
| 2. _____ | _____ | 4. _____ | _____ |

RECENT TRAVEL AND IMMUNIZATIONS

Have you traveled out of the country in the last 2 years?

NO _____ YES, traveled in _____

Write the dates for the shots you have had:

- | | | |
|---------------|--------------------|--------------------|
| Measles _____ | Mumps _____ | Flu _____ |
| Typhoid _____ | Yellow Fever _____ | Pneumococcus _____ |
| Tetanus _____ | | |

Have you had a tuberculin (TB) skin test? NO _____ YES _____ Date _____ of last TB skin test.

Results: POS. _____ NEG. _____ BCG _____

OTHER MEDICAL CARE

If you are being treated for any other illnesses or medical problems by another physician or physical or mental health practitioner, please
 describe the problems and write the name of the caregiver and facility name along with their city. Use extra page if more space is needed.

Illness or Medical Problem

Physician or Medical Facility

City

	Never	Occas.	Freq.
1. HEAD AND NECK			
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 _____

	Never	Occas.	Freq.
8. MUSCULOSKELETAL			
Physically handicapped/limited	YES _____	NO _____	
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. GENITAL			
Prostate trouble	_____	_____	_____
Trouble with sex organs	_____	_____	_____
Sores or lesions on penis	_____	_____	_____
Discharge from penis	_____	_____	_____
Pain or swelling in testicles	_____	_____	_____
Sexual problems or impotency	_____	_____	_____
Special problems-discuss with doctor	YES _____	NO _____	
12. SKIN			
Problems	YES _____	NO _____	
Dry skin/brittle fingernails	YES _____	NO _____	
Bruise easily	YES _____	NO _____	
Mole change	YES _____	NO _____	
Sores / cuts hard to heal	YES _____	NO _____	
Herpes simples	YES _____	NO _____	
13. NEUROLOGICAL			
Faintness	YES _____	NO _____	
Numbness	YES _____	NO _____	
Convulsions	YES _____	NO _____	
Tremors	YES _____	NO _____	
Coordination Problem	YES _____	NO _____	
Weakness/ Paralysis	YES _____	NO _____	

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/Runbella	___	___
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	___	___	Venereal 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:				ILLNESS	FAMILY MEMBER
Relationship	Age, if living	Age at Death	State of Health or Cause of Death		
Father	_____	_____	_____	Cancer	_____
Mother	_____	_____	_____	Diabetes	_____
Brothers	_____	_____	_____	Asthma/Emphysema/Bronchitis	_____
				Migraine Headaches	_____
Sisters	_____	_____	_____	Tuberculosis	_____
				Cystic Fibrosis	_____
Spouse	_____	_____	_____	Blood Disease	_____
Children	_____	_____	_____	Glaucoma	_____
				Epilepsy	_____
				Rheumatoid Arthritis	_____
				Gout	_____
				Peptic ulcer	_____
				Gallbladder disease	_____
				Colitis/Irritable bowel	_____
				Mental Problems	_____
				Multiple Sclerosis	_____

Brief description of your job and daily activities: _____

Brief description of your current living conditions: _____

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 Occasionlaly Frequently

Feel nervous? _____
Feel depressed? _____
Find it hard
to make decisions? _____
Tire easily? _____
Lose you temper? _____
Worry a lot? _____
Have trouble relaxng? _____
Having any sexual problems? _____
Ever feel like
commmitng suicide? _____
Feel bored with your life? _____

DO YOU FEEL: R Never Occasionlaly Frequently

Occupationlly satisfied? _____
Financially satisfied? _____
Sexually satisfied? _____
Recreationlly satisfied? _____
Your life is too crowded
or too overcommitted? _____
Hurried or pushed for time? _____
A vague sence 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 usually eat breakfast? Yes No

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

4. Do you snack? Yes No

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

6. Do you eat a balanced diet? Yes No

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

List any food supplements or vitamins you take regularly. _____