IDENTIFICATION DATA Please print the following information.

File no._____

Today's date ____/____/____

Name _____ ___ Male ___ Female ___ Race Date of Birth ____/____/____

Address _____ ___Married ___Separated ___Divorced ___Widowed ___Single

_____ _____ Zip Code

Education ____ years Elementary ____ years High School

Telephone _____ ____ years College, Business, etc.

Home number Work number

Social Security or Medicare No. _____ Occupation _____

FAMILY HISTORY: For each member of your family, follow the grey or white line across the page and check the boxes or: 1. Their present state of health 2. Any illnesses they have had.
(Note: except for *spouse*, Family refers to I*blood* or *natural* relatives.)

PRINT NAMES BELOW	Good health	Poor health	Deceased	Write in age and cause of death. Include fatal accidents & suicides.	Allergies or asthma	High cholesterol	Blood clotting problems	Diabetes	Cancer or tumor	Stroke	Glaucoma	Genetic disease	Alcoholism	Kidney or bladder trouble	Stomach/duodenal ulcer	Mental illness	Rheumatism or arthritis	High blood pressure	Heart trouble	Dementia	Gout	Other
Father:																						
Mother:																						
Brothers/Sisters:																						
Spouse:																						
Children:																						
Father's relatives (in each box, write how many affected with) →																						
Mother's relatives (in each box, write how many affected with) →																						
→Begin **YOUR HEALTH HISTORY** here. Have you had? →																						

Additional Illnesses or Problems: Mark an X in the box next to any of the following that you have now or have ever had.

☐ eye infections	☐ emphysema	☐ diverticulosis	☐ tension/anxiety	☐ high cholesterol	☐ malaria
☐ thyroid disease	☐ hepatitis	☐ hernia	☐ depression	☐ measles	☐ osteoporosis
☐ eczema	☐ pneumonia	☐ hemorrhoids	☐ childhood hyperactivity	☐ mumps	☐ mononucleosis
☐ hives or rashes	☐ pancreatitis	☐ blood transfusion	☐ drug abuse	☐ Sex. T. Diseases	☐ yellow jaundice
☐ bronchitis	☐ liver disease	☐ neuralgia or neuritis	☐ German measles	☐ rheumatic fever	☐ tuberculosis

Major Hospitalizations: If you have ever been hospitalized for any major medical illness or operation, write in your most recent hospitalizations below. Check this box ☐ if you have had more than three such hospitalizations. (Do not include normal pregnancies.)

	Year	Operation or Illness	Name of Hospital	City and State
1st Hospitalization				
2nd Hospitalization				
3rd Hospitalization				

Tests and Immunizations: Mark an X next to those that you have had. Enter the year when you last were given the tests or "shots".

	Year		Year		Year
☐	_____ chest x-ray	☐	_____ colonoscopy	☐	_____ PSA (prostate cancer screen)
☐	_____ kidney x-ray	☐	_____ PAP smear	☐	____ pneumonia shot
☐	_____ gastrointestinal series	☐	_____ mammogram		
☐	_____ colon x-ray	☐	_____ tetanus "shots"		
☐	_____ gallbladder x-ray	☐	_____ polio series		
☐	_____ electrocardiogram	☐	_____ flu injections		
☐	_____ TB test	☐	_____ measles&mumps "shots"		
☐	_____ sigmoidoscopy	☐	_____ hepatitis series		

Current Medications (include vitamins, supplements and over-the-counter drugs)

Medications	**Dose**	**How Often**

Allergies	**Reaction**

Please answer the following questions by writing an X on the line in front of the word Yes or No, except where you are asked for specific information.

Name _____

Date of Birth_____

- **If a question doesn't apply, skip it and go on to the next one.**
- **If for any reason you can't or don't want to answer a question, put a large dot (●) in the Yes space.**

1. Are you troubled with stiff or painful muscles or joints?	**1. ____ Yes ____ No**
2. Are your joints ever swollen?	**2. ____ Yes ____ No**
3. Are you troubled by pains in the back or shoulder?	**3. ____ Yes ____ No**
4. Are your feet often painful?	**4. ____ Yes ____ No**
5. Are you handicapped in any way?	**5. ____ Yes ____ No**
6. Do you have any skin problems?	**6. ____ Yes ____ No**
7. Does your skin itch or burn?	**7. ____ Yes ____ No**
8. Do you have trouble stopping even a small cut from bleedings?	**8. ____ Yes ____ No**
9. Do you bruise easily?	**9. ____ Yes ____ No**
10. Do you ever faint or feel faint?	**10. ____ Yes ____ No**
11. Is any part of your body always numb?	**11. ____ Yes ____ No**
12. Have you ever had seizures or convulsions?	**12. ____ Yes ____ No**
13. Has your handwriting changed lately?	**13. ____ Yes ____ No**
14. Do you have a tendency to shake or tremble?	**14. ____ Yes ____ No**
15. Are you very nervous around strangers?	**15. ____ Yes ____ No**
16. Do you find it hard to make decisions?	**16. ____ Yes ____ No**
17, Do you find it hard to concentrate or remember?	**17. ____ Yes ____ No**
18, Do you usually feel lonely or depressed?	**18. ____ Yes ____ No**
19. Do you often cry?	**19. ____ Yes ____ No**
20. Would you say you have a hopeless outlook?	**20. ____ Yes ____ No**
21. Do you have difficulty relaxing?	**21. ____ Yes ____ No**
22. Do you have a tendency to worry a lot?	**22. ____ Yes ____ No**
23. Are you troubled by frightening dreams or thoughts?	**23. ____ Yes ____ No**
24. Do you have a tendency to be shy or sensitive?	**24. ____ Yes ____ No**
25. Do you have a strong dislike for criticism?	**25. ____ Yes ____ No**
26. Do you lose your temper often?	**26. ____ Yes ____ No**
27. Do little things annoy you?	**27. ____ Yes ____ No**
28. Are you distrubed by any work or family problems?	**28. ____ Yes ____ No**
29. Are you having any sexual difficulties?	**29. ____ Yes ____ No**
30. Have you ever considered committing suicide?	**30. ____ Yes ____ No**
31. Have you ever desired or sought psychiatric help?	**31. ____ Yes ____ No**
32. Have you ever been the victim of abuse (physical, sexual, emotional)?	**32. ____ Yes ____ No**
33. Have you gained or lost more than 10 pounds in the last 6 months?	**33. ____ Yes ____ No**
34. Do you have a tendency to be too hot or too cold?	**34. ____ Yes ____ No**
35. Have you lost your interest in eating lately?	**35. ____ Yes ____ No**
36. Do you always seem to be hungry?	**36. ____ Yes ____ No**
37. Are you more thirsty than usual lately?	**37. ____ Yes ____ No**
38. Are there any swellings in your armpits or groin?	**38. ____ Yes ____ No**
39. Do you seem to feel exhausted or fatigued most of the time?	**39. ____ Yes ____ No**
40. Do you have difficulty either falling asleep or staying asleep?	**40. ____ Yes ____ No**
41. Do you participate in physical activity or exercise less than three times a week?	**41. ____ Yes ____ No**
42. How much do you smoke per day?	**42. ___ cigarettes ___ cigars/pipes ___ don't smoke**
43. Do you take two or more alcoholic drinks a day?	**43. ____ Yes ____ No**
44. Do you drink more than six cups/glasses of coffee, tea or pop/soda a day?	**44. ____ Yes ____ No**
45. Are you a regular user of sleeping pills, marijuana, tranquilizers, pain killers, etc?	**45. ____ Yes ____ No**
46. Have you ever used heroin, cocaine, LSD, PCP, meth, etc?	**46. ____ Yes ____ No**
47. Do you drive a motor vehicle more than 25,000 miles a year?	**47. ____ Yes ____ No**
48. How often do you use seat belts when riding in cars?	**48. ____ never ____ sometimes ____ always**
49. List any country outside the United States you have visited in the past six months	**49. _____**

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Name _____

Date of Birth_____

50. Are you troubled by heartburn? . . . . . 50. ____ Yes ____ No
51. Do you feel bloated after eating? . . . . . 51. ____ Yes ____ No
52. Are you troubled by belching? . . . . . 52. ____ Yes ____ No
53. Do you suffer discomfort in the pit of your stomach?. . . . . 53. ____ Yes ____ No
54. Do you easily become nauseated (feel like vomiting)? . . . . . 54. ____ Yes ____ No
55. Have you ever vomited blood? . . . . . 55. ____ Yes ____ No
56. Is it difficult or painful for you to swallow? . . . . . 56. ____ Yes ____ No
57. Are you constipated more than twice a month?. . . . . 57. ____ Yes ____ No
58. Are your bowel movements ever loose for more than one day? . . . . . 58. ____ Yes ____ No
59. Are your bowel movements ever black or bloody? . . . . . 59. ____ Yes ____ No
60. Are your bowel movements ever grey in color? . . . . . 60. ____ Yes ____ No
61. Do you suffer pains when you move your bowels? . . . . . 61. ____ Yes ____ No
62. Have you had any bleeding from your rectum? . . . . . 62. ____ Yes ____ No

63. Do you frequently get up at night to urinate? . . . . . 63. ____ Yes ____ No
64. Do you urinate more than five or six times a day? . . . . . 64. ____ Yes ____ No
65. Do you wet your pants or wet your bed? . . . . . 65. ____ Yes ____ No
66. Have you ever had burning or pains when you urinate? . . . . . 66. ____ Yes ____ No
67. Has your urine ever been brown, black or bloody? . . . . . 67. ____ Yes ____ No
68. Do you have any difficulty starting your urine flow? . . . . . 68. ____ Yes ____ No
69. Do you have a constant feeling that you have to urinate? . . . . . 69. ____ Yes ____ No

For Men Only

70. Are you homosexual or bisexual? . . . . . 70. ____ Yes ____ No
71. Have you had more than 5 sexual partners? . . . . . 71. ____ Yes ____ No
72. Is your urine stream very weak and slow? . . . . . 72. ____ Yes ____ No
73. Has a doctor ever told you that you have prostate trouble? . . . . . 73. ____ Yes ____ No
74. Have you had any burning or discharge from your penis? . . . . . 74. ____ Yes ____ No
75. Are there any swellings or lumps on your testicles? . . . . . 75. ____ Yes ____ No
76. Do your testicles get painful? . . . . . 76. ____ Yes ____ No
77. Write in month and year of your last PSA (Prostate Cancer Screening) . . . . . 77. ___ Mo. / ____ Yr.

For Women Only

78. What was the date of your last menstrual period? . . . . . 78. _____/____/_____
79. Are you past your menopause, or have you had a hysterectomy? . . . . . 79. ____ Yes ____ No
80. If yes: Have you noticed any vaginal bleeding since? . . . . . 80. ____ Yes ____ No
(Please now skip to question 84)
81. Was your last menstrual period normal? . . . . . 81. ____ Yes ____ No
82. Do you have heavy bleeding with your periods? . . . . . 82. ____ Yes ____ No
83. Have you had bleeding between your periods? . . . . . 83. ____ Yes ____ No
84. Do you ever have bleeding after intercourse? . . . . . 84. ____ Yes ____ No
85. Have you had any recent vaginal itching or discharge? . . . . . 85. ____ Yes ____ No
86. Do you examine your breasts at least once a month? . . . . . 86. ____ Yes ____ No
87. Have you ever noticed any lumps or pain in your breasts? . . . . . 87. ____ Yes ____ No
88. Have you had complications with any type of birth control? . . . . . 88. ____ Yes ____ No
89. Write in the month and year of your last Pap test . . . . . 89. ___ Mo. / ____ Yr.
90. Number of pregnancies . . . . . 90. _____
91. Number of children born alive . . . . . 91. _____
92. Number of premature births . . . . . 92. _____
93. Number of miscarriages . . . . . 93. _____
94. Number of stillbirths . . . . . 94. _____
95. Have you ever had an abortion? . . . . . 95. ____ Yes ____ No

Name _____

Date of Birth_____

96. Do you have headaches more than once a week?	96. ____ Yes ____ No
97. Does twisting your neck quickly cause pain?	97. ____ Yes ____ No
98. Have you ever had lumps or swelling in your neck?	98. ____ Yes ____ No
99. Do you wear glasses?	99. ____ Yes ____ No
100. Does your eyesight have blur?	100. ____ Yes ____ No
101. Is your eyesight getting worse?	101. ____ Yes ____ No
102. Do you ever see double?	102. ____ Yes ____ No
103. Do you ever see colored halos around lights?	103. ____ Yes ____ No
104. Do you ever have pains or itching in or around your eyes?	104. ____ Yes ____ No
105. Do your eyes blind or water most of the time?	105. ____ Yes ____ No
106. Have you had any trouble with your eyes in the last two years?	106. ____ Yes ____ No
107. Do you have difficulty hearing?	107. ____ Yes ____ No
108. Have you had any ear aches lately?	108. ____ Yes ____ No
109. Have you been troubled by ringing ears lately?	109. ____ Yes ____ No
110. Do you have a repeated buzzing or other noises in your ears?	110. ____ Yes ____ No
111. Do you get motion sickness riding in a car or plane?	111. ____ Yes ____ No
112. Do you have any problems with your teeth?	112. ____ Yes ____ No
113. Do you have any sore swellings on your gums or jaws?	113. ____ Yes ____ No
114. Is your tongue sore or sensitive?	114. ____ Yes ____ No
115. Have your taste senses changed lately?	115. ____ Yes ____ No
116. Is your nose stuffed up when you don't have a cold?	116. ____ Yes ____ No
117. Does your nose run when you don't have a cold?	117. ____ Yes ____ No
118. Do you ever hae sneezing spells?	118. ____ Yes ____ No
119. Do you ever have head colds two or more months in a row?	119. ____ Yes ____ No
120. Does your nose ever bleed for no reason at all?	120. ____ Yes ____ No
121. Is your throat ever sore when you don't have a cold?	121. ____ Yes ____ No
122. Has a doctor told you that your tonsils have been enlarged?	122. ____ Yes ____ No
123. Has your voice ever been hoarse when you didn't have a cold?	123. ____ Yes ____ No
124. Do you wheeze or have to gasp to breathe?	124. ____ Yes ____ No
125. Are you bothered by coughing spells?	125. ____ Yes ____ No
126. Do you cough up a lot of phlegm (thick spit)?	126. ____ Yes ____ No
127. Have you ever coughed up blood?	127. ____ Yes ____ No
128. Do you get chest colds more than once a month?	128. ____ Yes ____ No
129. Are you sweating more than usual or having night sweats?	129. ____ Yes ____ No
130. Have you ever been told that you had high blood pressure?	130. ____ Yes ____ No
131. Have you been bothered by a thumping or racing heart?	131. ____ Yes ____ No
132. Do you ever get pains or tightness in your chest?	132. ____ Yes ____ No
133. Do you have trouble with dizziness or lightheadedness?	133. ____ Yes ____ No
134. Does every little effort leave you short of breath?	134. ____ Yes ____ No
135. Do you wake up at night short of breath?	135. ____ Yes ____ No
136. Are you using more pillows to help you breathe at night?	136. ____ Yes ____ No
137. Do you have trouble with swollen feet or ankles?	137. ____ Yes ____ No
138. Are you getting cramps in your legs at night or upon walking?	138. ____ Yes ____ No
139. Have you ever been told that you have a heart murmur?	139. ____ Yes ____ No

Now, in the blank lines at the right please describe any special problems or symptoms that you wish to discuss with your doctor.

Special problems or symptoms: _____

_____

_____

_____

Your Signature: _____

END