

We ask that you take some time with this questionnaire so we can better help you. If any questions are difficult to answer please feel free to ask your doctor during your visit.

Today's Date _____
 Your Name _____ Next of Kin _____
 Date of Birth _____ Age _____ Female ___ Male ___ Marital Status _____
 Home Phone Number _____ Work Phone Number _____
 Occupation _____ Referred by _____

1. What **health problems** do you want to talk about when you are seen in the clinic?

2. **ALLERGIES:** Are you allergic to or have you had a "bad reaction" to any medicines or other substances?
 No ___ If yes, list the medicines _____
3. What **prescription medicines** do you presently take? (List doses and frequency) _____

4. Do you take any **non-prescription medicines**? For example: laxatives, vitamins, aspirin, antacids, or cold remedies?
 No ___ If yes, please list _____
5. **HOSPITALIZATIONS or SURGERIES:** (Type of illness / operation / place / year) _____

6. **VACCINATIONS:** (Include year if known) Measles _____ Mumps _____ Rubella _____ Tetanus _____
 Polio _____ Influenza _____ Hepatitis _____ Pneumonia _____

7. **YOUR HEALTH HISTORY:**

- Have you had any of the following?
 YES NO
- ___ ___ Anemia
 - ___ ___ Asthma
 - ___ ___ Cancer, if yes, kind and date _____
 - ___ ___ Emphysema
 - ___ ___ Heart disease
 - ___ ___ High blood pressure
 - ___ ___ Kidney stones
 - ___ ___ Liver disease, jaundice, hepatitis
 - ___ ___ Migraine
 - ___ ___ Serious injury or accident
 - ___ ___ Sugar diabetes
 - ___ ___ Thyroid gland trouble
 - ___ ___ Tuberculosis or positive skin test to TB
 - ___ ___ Sexually transmitted disease
 - ___ ___ Transfusions

8. **WOMEN'S HEALTH HISTORY:**

- Number of pregnancies _____
- Age of first menstrual period _____
- Age of menopause _____
- Current types of contraception _____
- Have you been on the pill? ___ When? _____
- Have you been on estrogen replacement?
 Yes ___ No ___
- Calcium Intake? Yes ___ No ___ Diet or Pills?

9. **HABITS** (Please Circle)

- Tobacco: Cigarettes ___ Pipe ___ Cigar ___ Chew ___
 # years _____ Daily amount _____
- Caffeine: # cups/day _____ Type _____
- Alcohol: None ___ Beer ___ Wine ___ Other Liquors ___
 Amount per week _____
- Do you use other drugs? Yes ___ No ___
- Hours sleep per night? ___ # meals per day _____
- Exercise? Yes ___ No ___
- Use Seatbelts? Yes ___ No ___
- Use Bicycle helmets? Yes ___ No ___
- Smoke Detectors? Yes ___ No ___

PLEASE CONTINUE ON THE OTHER SIDE. TURN THIS SHEET OVER.

10. **SYMPTOMS:** Please mark (x) in the available blanks if any of the following apply to you NOW or in the PAST.

NOW PAST HEAD, EYES, EARS, NOSE, THROAT

- Dizziness or ringing in ears
- Severe Headaches
- Glaucoma. Date checked: _____
- Eye exam. Date checked: _____
- Ear or hearing trouble
- Frequent nose trouble
- Persistent hoarseness
- Major Dental/Gum problems. Date of last dental exam: _____

LUNGS

- Daily cough
- Coughing blood
- Wheezing
- Shortness of breath

HEART - CIRCULATION

- Chest pain at rest
- Chest pain walking or exercising
- Heart palpitation / frequent skipped beats
- Leg vein trouble
- Leg pain when walking
- Ankle swelling

STOMACH, INTESTINAL

- Trouble swallowing
- Frequent or severe nausea or vomiting
- Frequent or severe heartburn or indigestion
- Frequent or severe stomach pain
- Vomiting blood
- Yellow jaundice
- Bowel habit change
- Prolonged or frequent diarrhea
- Constipation
- Blood in bowel movements
- Hemorrhoids

URINARY

- Frequent urination
- Frequent urinary tract infection
- Bloody urine
- Trouble starting urine
- Urinate more than 2 times a night
- Leak of urine

BONES, JOINTS, MUSCLES

- Joints pain and swelling
- Back pain longer than 1 month
- Muscle weakness
- Neck pain longer than 1 month
- Sciatica

NOW PAST NERVOUS SYSTEM

- Lack of energy or fatigue
- Frequent loss of balance
- Fainting spells (black outs)
- Convulsions (seizures, epilepsy)
- Tremor (shaking, trembling)
- Paralysis
- Numbness (body parts "fall asleep")
- Nervousness
- Excessive worry
- Trouble sleeping
- Memory trouble
- Trouble concentrating
- Depression
- Crying spells
- Feeling of worthlessness
- Trouble getting along with people

FEMALES

- Breast lumps or discharge
- Unusual bleeding from vagina
- Unusual discharge from vagina
- Sexual trouble
- Abnormal pap smear. Date of last pap smear: _____
- Abnormal mammogram. Date of last mammogram: _____

MALES

- Discharge from penis
- Bladder or prostate infection
- Sexual trouble

GENERAL

- Unexplained weight loss or gain
- Unexplained fever
- Night sweats
- Persistent skin rash or itching
- Change in appetite
- Change in sleep

11. WHICH OF YOUR BLOOD RELATIVES HAVE HAD ANY OF THE FOLLOWING DISEASES:

- Early coronary heart disease _____
- Diabetes _____
- High blood pressure _____
- Mental or emotional disease _____
- Tuberculosis _____
- Alcohol or substance abuse _____
- Cancer:
 - Breast _____ Ovary _____
 - Colon _____ Prostate _____

12. CHILDREN

- Number of children _____
- Health status _____