Today's date ____/____/____ ID: ____

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.

EMAIL ADDRESS: 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 for:
1. Their present state of health 2. Any illnesses they have had

(Note: except for *spouse*, Family refers to *blood* or *natural* relatives.)

PRINT NAMES BELOW

	Good health	Poor health	Deceased → Write in age and cause of death. Include fatal accidents and suicides.	Allergies or asthma	Anemia	Blood clotting problems	Diabetes	Cancer or tumor	Epilepsy	Glaucoma	Genetic disease	Alcoholism	Kidney or bladder trouble	Stomach/duodenal ulcer	Nervous breakdown	Rheumatism or arthritis	High blood pressure	Heart trouble	Gout
Father:																			
Mother:																			
Brothers/Sisters:																			
Spouse:																			
Child:																			
Child:																			
Child:																			
Child:																			
Paternal relatives (in each box, write how many affected with) →																			
Maternal 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
- ☐ thyroid disease
- ☐ eczema
- ☐ hives or rashes
- ☐ bronchitis
- ☐ emphysema
- ☐ hepatitis
- ☐ pneumonia
- ☐ pancreatitis
- ☐ liver disease
- ☐ diverticulosis
- ☐ hernia
- ☐ hemorrhoids
- ☐ blood transfusion
- ☐ neuralgia or neuritis
- ☐ tension/anxiety
- ☐ depression
- ☐ childhood hyperactivity
- ☐ chicken pox
- ☐ German measles
- ☐ drug abuse
- ☐ scarlet fever
- ☐ measles
- ☐ mumps
- ☐ polio
- ☐ rheumatic fever
- ☐ malaria
- ☐ osteoporosis
- ☐ mononucleosis
- ☐ sexually transmitted disease
- ☐ yellow jaundice
- ☐ 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 four such hospitalizations. (Do not include normal pregnancies)

	Year	Operation or Illness	Name of Hospital	City and State
1st Hospitalization				
2nd Hospitalization				
3rd Hospitalization				
4th 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
☐	_____ chest x-ray	☐	_____ mammogram
☐	_____ kidney x-ray	☐	_____ tetanus "shots"
☐	_____ G.I. series	☐	_____ polio series
☐	_____ colon x-ray	☐	_____ typhoid "shots"
☐	_____ gallbladder x-ray	☐	_____ flu injections
☐	_____ electrocardiogram	☐	_____ mumps "shots"
☐	_____ TB test	☐	_____ measles "shots"
☐	_____ sigmoidoscopy	☐	_____ hepatitis
		☐	_____ _____

Medicines: Mark an X in the box next to any medicines that you are now taking, or that you are sensitive or allergic to.

taking	allergic to:		taking	allergic to:	
☐	☐	antibiotics	☐	☐	aspirin
☐	☐	penicillin	☐	☐	diet pills
☐	☐	sulfa	☐	☐	antacids
☐	☐	opiates/codeine	☐	☐	laxatives
☐	☐	diuretics/water pills	☐	☐	cold tablets
☐	☐	sedatives	☐	☐	_____
☐	☐	stimulants/caffeine	☐	☐	_____
☐	☐	Demerol	☐	☐	_____
☐	☐	blood pressure medicine	☐	☐	_____

Your Signature _____

CONTINUE TO NEXT PAGE

- Answer each question by writing an X on either the No or Yes line.
- Where a question asks for specific information, write the answer on the line next to the question number on the last page.
- If you don't understand a question, or would especially like to discuss it with the doctor, circle its number on the last page (Example:___ Yes (17)).

tient No. _____

1. Do you have any skin problems?	No ___	___ Yes	1.
2. Does your skin itch or burn?	No ___	___ Yes	2.
3. Do you have trouble stopping even a small cut from bleeding?	No ___	___ Yes	3.
4. Do you bruise easily?	No ___	___ Yes	4.
5. Do you ever faint or feel faint?	No ___	___ Yes	5.
6. Is any part of your body always numb?	No ___	___ Yes	6.
7. Have you ever had seizures or convulsions?	No ___	___ Yes	7.
8. Has your handwriting changed lately?	No ___	___ Yes	8.
9. Do you have a tendency to shake or tremble?	No ___	___ Yes	9.
10. Are you very nervous around strangers?	No ___	___ Yes	10.
11. Do you find it hard to make decisions?	No ___	___ Yes	11.
12. Do you find it hard to concentrate or remember?	No ___	___ Yes	12.
13. Do you usually feel lonely or depressed?	No ___	___ Yes	13.
14. Do you often cry?	No ___	___ Yes	14.
15. Would you say you have a hopeless outlook?	No ___	___ Yes	15.
16. Do you have difficulty relaxing?	No ___	___ Yes	16.
17. Do you have a tendency to worry a lot?	No ___	___ Yes	17.
18. Are you troubled by frightening dreams or thoughts?	No ___	___ Yes	18.
19. Do you have a tendency to be shy or sensitive?	No ___	___ Yes	19.
20. Do you have a strong dislike for criticism?	No ___	___ Yes	20.
21. Do you lose your temper often?	No ___	___ Yes	21.
22. Do little things often annoy you?	No ___	___ Yes	22.
23. Are you disturbed by any work or family problems?	No ___	___ Yes	23.
24. Are you having any sexual difficulties?	No ___	___ Yes	24.
25. Have you ever considered committing suicide?	No ___	___ Yes	25.
26. Have you ever desired or sought psychiatric help?	No ___	___ Yes	26.
27. Have you gained or lost more than 10 pounds in the last 6 months?	No ___	___ Yes	27.
28. Do you have a tendency to be too hot or too cold?	No ___	___ Yes	28.
29. Have you lost your interest in eating lately?	No ___	___ Yes	29.
30. Do you always seem to be hungry?	No ___	___ Yes	30.
31. Are you more thirsty than usual lately?	No ___	___ Yes	31.
32. Are there any swellings in your armpits or groin?	No ___	___ Yes	32.
33. Do you seem to feel exhausted or fatigued most of the time?	No ___	___ Yes	33.
34. Do you have difficulty either falling asleep or staying asleep?	No ___	___ Yes	34.
35. Do you exercise more than three times a week?	**Yes** ___	___ No	35.
36. How much do you smoke per day?		___cigarettes	36.
		___cigars/pipes	
		doesn't smoke	
37. Do you take two or more alcoholic drinks a day?	No ___	___ Yes	37.
38. Do you drink more than six cups/glasses of coffee, tea or cola soda per day?	No ___	___ Yes	38.
39. Are you a regular user of sleeping pills, marijuana, tranquilizers, pain killers, etc.?	No ___	___ Yes	39.
40. Have you ever used heroin, cocaine, LSD, PCP, etc.?	No ___	___ Yes	40.
41. Do you drive a motor vehicle more than 25,000 miles per year?	No ___	___ Yes	41.
42. How often do you use seat belts when riding in cars?		___never	42.
		___sometimes	
	___	always	
43. List any country outside the United States you have visited in the past six months		_____	43.

TURN TO THE NEXT PAGE

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

56. Do you frequently get up at night to urinate? ..... No ___ ___ Yes
57. Do you urinate more than five or six times a day? ..... No ___ ___ Yes
58. Do you wet your pants or wet your bed? ..... No ___ ___ Yes
59. Have you ever had burning or pains when you urinate? ..... No ___ ___ Yes
60. Has your urine ever been brown, black or bloody? ..... No ___ ___ Yes
61. Do you have any difficulty starting your urine flow? ..... No ___ ___ Yes
62. Do you have a constant feeling that you have to urinate? ... No ___ ___ Yes

For Men Only

63. Is your urine stream very weak and slow? ..... No ___ ___ Yes
64. Has a doctor ever told you that you have prostate trouble? ... No ___ ___ Yes
65. Have you had any burning or discharge from your penis? ... No ___ ___ Yes
66. Are there any swellings or lumps on your testicles? ..... No ___ ___ Yes
67. Do your testicles get painful? ..... No ___ ___ Yes

For Women Only

68. What was the date of your last menstrual period? ..... ___/___/___
69. Are you past your menopause, or have you had a hysterectomy? No ___ ___ Yes
70. If yes: Have you noticed any vaginal bleeding since? ..... No ___ ___ Yes
(Please now skip to question 74)
71. Was your last menstrual period normal? ..... **Yes** ___ ___ No
72. Do you have heavy bleeding with your periods? ..... No ___ ___ Yes
73. Have you had bleeding between your periods? ..... No ___ ___ Yes
74. Do you ever have bleeding after intercourse? ..... No ___ ___ Yes
75. Have you had any recent vaginal itching or discharge? ..... No ___ ___ Yes
76. Do you examine your breasts at least once a month? ..... **Yes** ___ ___ No
77. Have you ever noticed any lumps or pain in your breasts? ... No ___ ___ Yes
78. Have you had complications with any type of birth control? No ___ ___ Yes
79. Write in the month and year of your last Pap test ..... ___/___/___ Mo. Yr.

Print the following information in the spaces at the right:

80. Number of pregnancies .....
81. Number of children born alive .....
82. Number of premature births .....
83. Number of miscarriages .....
84. Number of stillbirths .....
85. Have you ever had an abortion? ..... No ___ ___ Yes

Questions 86-134 For Both Men and Women

86. Are you troubled with stiff or painful muscles or joints? ..... No ___ ___ Yes
87. Are your joints ever swollen? ..... No ___ ___ Yes
88. Are you troubled by pains in the back or shoulder? ..... No ___ ___ Yes
89. Are your feet often painful? ..... No ___ ___ Yes
90. Are you handicapped in any way? ..... No ___ ___ Yes

TURN TO BACK OF THIS PAGE

HEAD and NECK

91. Do you have headaches more than once a week? ..... No___ Yes ___ frequent headaches
92. Does twisting your neck quickly cause pain? ..... No___ Yes ___ neck pains
93. Have you ever had lumps or swelling in your neck? ..... No___ Yes ___ neck lumps or swelling

EYES

94. Do you wear glasses? ..... No___ Yes ___ wears glasses
95. Does your eyesight ever blur? ..... No___ Yes ___ blurry vision
96. Is your eyesight getting worse? ..... No___ Yes ___ eyesight worsening
97. Do you ever see double? ..... No___ Yes ___ sees double
98. Do you ever see colored halos around lights? ..... No___ Yes ___ sees halo
99. Do you ever have pains or itching in or around your eyes? ... No___ Yes ___ eye pains or itching
100. Do your eyes blink or water most of the time? ..... No___ Yes ___ watering eyes
101. Have you had any trouble with your eyes in the last two years? No___ Yes ___ eye trouble

EARS

102. Do you have difficulty hearing? ..... No___ Yes ___ hearing difficulties
103. Have you had any earaches lately? ..... No___ Yes ___ earaches
104. Have you been troubled by ringing ears lately? ..... No___ Yes ___ ringing ears
105. Do you have a repeated buzzing or other noises in your ears? No___ Yes ___ buzzing in ears
106. Do you get motion sickness riding in a car or plane? ..... No___ Yes ___ motion sickness

MOUTH

107. Do you have any problems with your teeth? ..... No___ Yes ___ dental problems
108. Do you have any sore swellings on your gums or jaws? .... No___ Yes ___ swellings on gums or jaws
109. Is your tongue sore or sensitive? ..... No___ Yes ___ sore tongue
110. Have your taste senses changed lately? ..... No___ Yes ___ taste changes

NOSE and THROAT

111. Is your nose stuffed up when you don't have a cold? ..... No___ Yes ___ congested nose
112. Does your nose run when you don't have a cold? ..... No___ Yes ___ running nose
113. Do you ever have sneezing spells? ..... No___ Yes ___ sneezing spells
114. Do you ever have head colds two or more months in a row? No___ Yes ___ headcolds
115. Does your nose ever bleed for no reason at all? ..... No___ Yes ___ nose bleeds
116. Is your throat ever sore when you don't have a cold? ..... No___ Yes ___ sore throat
117. Has a doctor told you that your tonsils have been enlarged? No___ Yes ___ enlarged tonsils
118. Has your voice ever been hoarse when you didn't have a cold? No___ Yes ___ hoarse voice

RESPIRATORY

119. Do you wheeze or have to gasp to breathe? ..... No___ Yes ___ wheezes or gasps
120. Are you bothered by coughing spells? ..... No___ Yes ___ coughing spells
121. Do you cough up a lot of phlegm (thick spit)? ..... No___ Yes ___ coughs up phlegm
122. Have you ever coughed up blood? ..... No___ Yes ___ coughed up blood
123. Do you get chest colds more than once a month? ..... No___ Yes ___ chest colds
124. Are you sweating more than usual or having night sweats? ... No___ Yes ___ more sweating, night sweats

CARDIOVASCULAR

125. Have you ever been told that you had high blood pressure? No___ Yes ___ high blood pressure
126. Have you been bothered by a thumping or racing heart? ... No___ Yes ___ racing heart
127. Do you ever get pains or tightness in your chest? ..... No___ Yes ___ chest pains
128. Do you have trouble with dizziness or lightheadedness? ... No___ Yes ___ dizzy spells
129. Does every little effort leave you short of breath? ..... No___ Yes ___ shortness of breath
130. Do you wake up at night short of breath? ..... No___ Yes ___ shortness of breath at night
131. Are you using more pillows to help you breathe at night? ... No___ Yes ___ more pillows to breathe
132. Do you have trouble with swollen feet or ankles? ..... No___ Yes ___ swollen feet or ankles
133. Are you getting cramps in your legs at night or upon walking? No___ Yes ___ leg cramps
134. Have you ever been told that you have a heart murmur? ... No___ Yes ___ heart murmur