NAME_____ DATE: _____

Please review the list below. Check in the box if you have had any of the following. Leave the box blank if not.
Use the space to the right or at the bottom of the list to explain any positive answers.

Have you ever had:	**YES**	**Have you ever had:**	**YES**
Unexplained weight loss		Chronic/recurrent fever	
Loss of appetite		Temperature intolerance	
Skin disease		Rashes that return or don't clear up	
Hives or eczema		Frequent skin infections or boils	
Abnormal moles		Eye diseases	
Blurred vision		Need for glasses or contacts	
Eye pain		Glaucoma	
Frequent headaches		Itchy eyes, runny nose, sneezing	
Frequent nosebleeds		Chronic ringing in the ears	
Sinus troubles		Hearing loss or disease of the ears	
Dizziness or fainting spells		Neck stiffness	
Neck injury		Enlarged glands in the neck	
Coughing/spitting blood		Asthma or wheezing	
Chronic cough		Shortness of breath	
Difficulty walking 2 blocks		Night sweats	
Positive test for tuberculosis		Chest pain or angina	
Heart trouble		Heart attack or heart disease	
Shortness of breath when lying down		Waking up short of breath	
Heart murmurs		Rapid or skipped heartbeats	
Swelling of the feet or ankles		Stomach or duodenal ulcer	
Heartburn or indigestion		Sour taste in your mouth or throat	
Regular use of Tums or other antacid		Intolerance to specific food types	
Vomiting up blood		Gallbladder trouble	
Cramping or abdominal pain		Liver problems or jaundice	
Chronic constipation		Frequent diarrhea	
Laxative use		Change in bowel habits	
Bloody or black stools		Hemorrhoids or piles	
Leak urine with coughing or sneezing		Frequent bladder or kidney infections	
Burning or painful urination		Night time urination	
Urgency in urination (have to go NOW)		Bloody, pink or brown urine	
Kidney stones		Arthritis	

Weakness in arms or legs		Difficulty walking	
Pain in calves or buttocks with walking		Painful varicose veins	
History of stroke		Seizures	
Paralysis		Numbness or tingling	
Loss of consciousness		Poor sleep	
Feeling anxious or worried often		Feeling depressed	
Thoughts of death		Feeling hopeless or helpless	
History of anemia		Unexplained bruising	
Excessive bleeding		History of hormone therapy	
Thyroid disease		Change in voice	
Change in skin or hair texture		Feeling thirsty all the time	

FOR MEN ONLY:

Difficulty starting urination		Decrease in strength of urine stream	
Discharge from penis		Difficulty with erections	
Prostate problems			

FOR WOMEN ONLY: **DATE OF LAST MENSTRUAL PERIOD: _____ Last Pap? _____**

Age when periods started		Frequency of periods (every ____ days)	
Number of pregnancies		Number of deliveries (live birth)	
Abnormal discharge or odor		Extreme pain with periods	
Pain with intercourse		Breast lumps or pain	

EXPLAIN ANY POSITIVES (items you checked, use back of page if needed):

_____

_____

_____

_____

FAMILY HISTORY. Please give us a sense of your family's well being. For each relative below, list any medical problems. If your family member is deceased, please give the age at which he or she passed away and a cause (if known). Include any mental problems, such as depression, anxiety or addiction and substance abuse, please. Again, use the back if needed.

MOTHER: _____ FATHER: _____

BROTHERS AND SISTERS (how many of each): _____

CHILDREN (how many?) _____

When was your last TETANUS shot? _____ Have you had Colonoscopy (when)? _____