

Last Name	First	Middle	Birth-date	Date
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Address	City	State	Zip	Home Phone	Business Phone
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Describe briefly the problems that brought you here for this examination or consultation.

To be answered by men and women: (circle)

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|-----|----|--|-----------|-------|---|
| Yes | No | Do you frequently have severe headaches? (If yes, answer the following): | | | |
| Yes | No | Do they cause visual trouble? | | | |
| Yes | No | Do they occur on one side of the head? | | | |
| Yes | No | Do they awaken you at night from sleep? | | | |
| Yes | No | Do they feel like a tight hat band? | | | |
| Yes | No | Do they hurt most in the back of the head and neck? | | | |
| Yes | No | Does aspirin relieve them? | | | |
| Yes | No | Have you ever fainted? | Yes | No | Have you ever had a convulsion? |
| Yes | No | Spells of dizziness? | Yes | No | Double vision? |
| Yes | No | Spells of weakness in an arm or leg? | Yes | No | Nosebleeds? |
| Yes | No | Ringing in ears? | | | |
| Yes | No | Do you have bleeding gums? | Yes | No | Do you frequently have nausea and vomiting? |
| Yes | No | Do you frequently have trouble swallowing? | | | |
| Yes | No | Do you have frequent hoarseness? | | | |
| Yes | No | Do you have shortness of breath? | Yes | No | Have you ever coughed up blood? |
| Yes | No | Do you have a chronic cough? | Yes | No | Do you cough up sputum? |
| Yes | No | Do you have wheezing? | | | |
| Yes | No | Have you ever had chest pains or tightness in the chest? | | | |
| Yes | No | Does your heart pound or skip beats? | | | |
| Yes | No | Do you have stomach pain or distress? | | | |
| Yes | No | Do you have nausea or vomiting? | | | |
| Yes | No | Is there heartburn? | | | |
| Yes | No | Are you bothered by gas? | | | |
| Yes | No | Do you suffer from constipation? | | | |
| Yes | No | Is there diarrhea or loose bowel movements? | | | |
| Yes | No | Do you have loss of appetite? | | | |
| Yes | No | Gain or loss of weight in the last year? | How Much? | _____ | |
| Yes | No | Has there been a change in your bowel movements in the last year? | | | |
| Yes | No | Do you have rectal pain or hemorrhoids? | | | |
| Yes | No | Mucus in the stool? | | | |
| Yes | No | Blood in the stool? | | | |
| Yes | No | Blood on the toilet paper? | | | |
| Yes | No | Black stools? | | | |
| Yes | No | Require the use of strong laxatives or enemas? | | | |
| Yes | No | Have you ever been jaundiced or had hepatitis? | | | |

- Yes No Burning when urinating?
- Yes No Loss of control of bladder?
- Yes No Blood in the urine?
- Yes No Dark-colored urine?
- Yes No Trouble starting to urinate?
- Yes No Trouble holding the urine?
- Yes No Trouble holding the urine?
- Yes No Getting up frequently at night?
- Yes No Passed a kidney stone?

In the LAST YEAR have you had: (circle)

- Yes No Pains in calves of legs when walking?
- Yes No Cramps in legs at night?
- Yes No Varicose veins?
- Yes No Phlebitis or inflamed leg veins?
- Yes No Swelling in the ankles?
- Yes No Do you have aching or painful joints?
- Yes No Swollen or reddening of joints?
- Yes No Backache?
- Yes No Morning stiffness?
- Yes No Skin rashes or itching?

- Yes No Do you have trouble sleeping?
- Yes No Are you blue or depressed?
- Yes No Are you nervous or anxious?
- Yes No Have you considered suicide?
- Yes No Do you have problems with your marriage?
- Yes No Do you have sexual problems or questions?
- Yes No Do you have family problems or concerns?

To be answered by MEN ONLY: In the LAST YEAR have you had: (circle)

- Yes No Loss of sexual activity? For how long? _____
- Yes No Treatment of genitals (private parts)?
- Yes No Discharge from penis?
- Yes No Hernia (rupture)?
- Yes No Prostate trouble?

To be answered by WOMEN ONLY: (circle)

- Yes No Are you still having regular monthly menstrual periods?
- Yes No Have you ever had bleeding between you periods? When? _____
- Yes No Do you have very heavy bleeding with your periods? When? _____
- Yes No Do you feel bloated and irritable before you period?
- Yes No Are you now on or have you ever been on the birth control pill? When? _____
- Yes No Have you ever had a miscarriage? When? _____
- Yes No Have you ever had a discharge from the nipple of your breast? When? _____
- Yes No Do you regularly have the cancer test of the cervix? Date of last test _____
- How many children born alive? _____ How many cesarean operations? _____
- How many stillbirths? _____ Any complications of pregnancy? _____
- How many premature births? _____ Date of last menstrual period? _____
- How many miscarriages? _____ How many days do you bleed? _____
- _____ How often does your period come? _____

Any changes in your family medical history in the last year? (circle)

- | | | | | | | | | | | | |
|---------------|----|---------------------------|-----|-------------------------|---------|-----|----|----------------|-----|----|-----------|
| Yes | No | Strokes? | Yes | No | Cancer? | Yes | No | Heart Disease? | Yes | No | Diabetes? |
| Explain _____ | | | | | | | | | | | |
| Yes | No | Do you use tobacco? | | If yes, how much? _____ | | | | | | | |
| Yes | No | Do you drink alcohol? | | If yes, how much? _____ | | | | | | | |
| Yes | No | Do you use illicit drugs? | | If yes, how much? _____ | | | | | | | |
| Yes | No | Do you use seat belts? | | | | | | | | | |