|  |  |  |  |
| --- | --- | --- | --- |
| NAME (LAST, FIRST, MI) | ID NUMBER: | DATE OF BIRTH | AGE |
| ADDRESS: | CITY | STATE/ZIP |
| JOB TITLE: | HOME PHONE( ) | WORK PHONE( ) |

|  |  |
| --- | --- |
| CURRENT MEDICATIONS, DOSE AND FREQUENCY: | ALLERGIES: |
| PREVIOUS SURGERY(IES), REASON(S), DATE(S): |
| PREVIOUS HOSPITALIZATION(S), REASON(S), DATES(S) |

|  |  |  |  |
| --- | --- | --- | --- |
| **IMMUNIZATIONS:** | (date) | **HEALTH MAINTENANCE:** | (date/results) |
| Tetanus | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cholesterol | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Hepatitis B | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Hep. B Titer | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Flu | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Colonoscopy | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | PSA | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **CHEST X-RAY** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Mammogram & PAP | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**HAVE YOU *EVER HAD* ANY OF THE FOLLOWING CONDITIONS?**

*Please answer the following questions honestly and completely.*  ***Any “YES” answer must be explained on the last page.***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **YES** | **NO** |  |  | **YES** | **NO** |
| 1. Emphysema | □ | □ |  | 18. Angina | □ | □ |
| 2. Asthma | □ | □ |  | 19. Heart Failure | □ | □ |
| 3. Pneumonia | □ | □ |  | 20. High Cholesterol | □ | □ |
| 4. Pneumothorax | □ | □ |  | 21. High Blood Pressure | □ | □ |
| 5. Blood Clot in the Lungs | □ | □ |  | 22. Arthritis / Rheumatism | □ | □ |
| 6. Kidney Disease | □ | □ |  | 23. Glaucoma | □ | □ |
| 7. Prostatitis | □ | □ |  | 24. Epilepsy | □ | □ |
| 8. Colitis | □ | □ |  | 25. Convulsions / Seizures | □ | □ |
| 9. Hepatitis | □ | □ |  | 26. Stroke | □ | □ |
| 10. Liver Disease | □ | □ |  | 27. Diabetes | □ | □ |
| 11. Elevated Liver Enzyme Test | □ | □ |  | 28. Thyroid Trouble | □ | □ |
| 12. Pancreatitis | □ | □ |  | 29. Anemia | □ | □ |
| 13. Ulcer | □ | □ |  | 30. Eczema | □ | □ |
| 14. Heart Attack | □ | □ |  | 31. Cancer (including skin cancer) | □ | □ |
| 15. Heart Murmur | □ | □ |  | 32. Sleep Apnea | □ | □ |
| 16. Positive Cardiac Stress Test | □ | □ |  | 33. Chronic Muscular Disease | □ | □ |
| 17. Heart Valve Abnormality | □ | □ |  | 34. Chronic Neurological Disease | □ | □ |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYMPTOMS**

**Do you *currently have* or *have you recently had* any of the following*? Explain ALL “YES” answers on the last page.***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **YES** | **NO** |  |  | **YES** | **NO** |
| **EYES / EARS / NOSE THROAT** |  |  |  | **CENTRAL NERVOUS SYSTEM** |  |  |
| 35. Difficulty with night vision | □ | □ |  | 73. Fainting spells | □ | □ |
| 36. Change in vision | □ | □ |  | 74. Recurrent dizziness | □ | □ |
| 37. Blurred or double vision | □ | □ |  | 75. Frequent headaches | □ | □ |
| 38. Bleeding gums | □ | □ |  | 76. Tremors | □ | □ |
| 39. Frequent nose bleeds | □ | □ |  | 77. Memory loss | □ | □ |
| 40. Frequent sinus trouble | □ | □ |  | 78. Loss of coordination | □ | □ |
| 41. Recent hoarseness | □ | □ |  | 79. Numbness / tingling in extremities | □ | □ |
| 42. Ringing / buzzing in the ears | □ | □ |  | 80. Loss of consciousness | □ | □ |
| 43. Ear ache | □ | □ |  |  |  |  |
| 44. Loss of hearing |  |  |  | M**USCULO / SKELETAL** |  |  |
|  |  |  |  | 81. Back trouble / pain | □ | □ |
| **PULMONARY** |  |  |  | 82. Neck trouble / pain | □ | □ |
| 45. Shortness of breath | □ | □ |  | 83. Joint injury / pain / swelling | □ | □ |
| 46. Chronic or frequent cough | □ | □ |  | 84. Carpal Tunnel Syndrome | □ | □ |
| 47. Brown or blood-tinged sputum | □ | □ |  |  |  |  |
| 48. Chest tightness | □ | □ |  | **MENTAL HEALTH** |  |  |
| 49. Wheezing | □ | □ |  | 85. Recurrent nightmares | □ | □ |
| 50. Chronic bronchitis | □ | □ |  | 86. Intrusive images | □ | □ |
|  |  |  |  | 87. Inability to focus | □ | □ |
| **GENITO-URINARY** |  |  |  | 88. Difficulty concentrating | □ | □ |
| 51. Bladder trouble | □ | □ |  | 89. Anxiety | □ | □ |
| 52. Blood in urine | □ | □ |  | 90. Panic attacks | □ | □ |
| 53. Difficulty starting/stopping urination | □ | □ |  | 91. Depression | □ | □ |
| 54. Urinating 3+ times per night | □ | □ |  | 92. Fear of heights | □ | □ |
| 55. Frequent or painful urination | □ | □ |  | 93. Claustrophobia | □ | □ |
| *Women Only* |  |  |  |  |  |  |
| 56. Currently pregnant | □ | □ |  | **MISCELLANEOUS** |  |  |
| 57. Irregular vaginal bleeding | □ | □ |  | 94. Bleeding / bruising easily | □ | □ |
|  |  |  |  | 95. Enlarged glands | □ | □ |
| **GASTROINTESTINAL** |  |  |  | 96. Rashes | □ | □ |
| 58. Vomiting blood | □ | □ |  | 97. Unexplained lumps | □ | □ |
| 59. Persistent diarrhea | □ | □ |  | 98. Chronic fatigue | □ | □ |
| 60. Persistent constipation | □ | □ |  | 99. Night sweats | □ | □ |
| 61. Frequent abdominal pain | □ | □ |  | 100. Undesired weight loss | □ | □ |
| 62. Frequent nausea | □ | □ |  | 101. Snoring | □ | □ |
| 63. Frequent indigestion / heartburn | □ | □ |  | 102. Difficulty sleeping | □ | □ |
| 64. Black or bloody bowel movement | □ | □ |  | 103. Low blood sugar | □ | □ |
| 65. Hemorrhoids | □ | □ |  | 104. Unexplained fever | □ | □ |
| 66. Trouble swallowing | □ | □ |  | 105. Decreased stamina | □ | □ |
| 67. Hernia | □ | □ |  | 106. Any other medical condition |  |  |
|  |  |  |  |  |  |  |
| **HEART / VASCULAR** |  |  |  | **OCCUPATIONAL EXPOSURES** |  |  |
| 68. Palpitations (irregular heartbeat) | □ | □ |  | 107. Exposure to noise | □ | □ |
| 69. Pain or discomfort in the chest | □ | □ |  | 108. Exposure to asbestos | □ | □ |
| 70. Swelling of the feet / ankles | □ | □ |  | 109. Exposure to heavy metals | □ | □ |
| 71. Leg pain while walking | □ | □ |  | 110. Exposure to toxic substances | □ | □ |
| 72. Painful varicose veins | □ | □ |  | 111. Exposure to hazardous materials | □ | □ |

**EMPLOYMENT HISTORY**

|  |  |  |
| --- | --- | --- |
| Employer | General Job Duties | Years in Position |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**FAMILY AND SOCIAL HISTORY**

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** |  |
|  |  | **Does anyone in your immediate family:**  |
| □ | □ | Have a history of heart disease or stroke? |
| □ | □ | Have cancer? |
| □ | □ | Have high blood pressure? |
| □ | □ | Have diabetes? |
| □ | □ | **Do you smoke?** □ cigarettes □ cigars □ smokeless / chewing tobacco / snuff |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_ number per day \_\_\_\_\_\_\_\_\_\_\_\_\_ years |
| □ | □ | **Have you quit smoking?** |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_ when quit \_\_\_\_\_\_\_\_\_\_\_\_\_ years smoked before quitting |
| □ | □ | **Do you drink alcohol?** |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_ type \_\_\_\_\_\_\_\_\_\_\_\_\_ number of drinks per day / week |
| □ | □ | **Do you exercise regularly?** |
|  |  | Type:Frequency: |
| □□ | □□ | **Do you wear contact lenses?** If checked: □ hard lenses or □ soft lenses**Do you wear glasses?** |

**EXPLANATIONS TO “YES” ANSWERS**

|  |  |
| --- | --- |
| **QUESTION #** | **EXPLANATION** |
|  |  |
|  |  |
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