In order to obtain a comprehensive evaluation of your health, your doctor asks that you carefully complete this questionnaire. This form is intended to supplement your interview and is entirely confidential. Thank you.

**Occupation:**

**Drug Allergies & Reactions:**

**Medications** (include vitamins, over-the-counter meds, oral contraceptives):

**Social Habits:** Check and describe all that apply.

- Caffeine
- Alcohol
- Exercise
- Sexually Active

**Women:** Date of last period  
Women: Date of last period  
Women: Date of last period  
Women: Date of last period

**Medical Illnesses** (e.g. diabetes, cancer, lung/heart/stomach/kidney/liver disease, nervous or psychiatric disorders):

**Surgeries/Hospitalization** (e.g. appendix, tonsils, hysterectomy, vasectomy, etc.):

**Family History:**

**Health Maintenance:** Please indicate the year you last had the following:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB Skin Test</td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td></td>
</tr>
<tr>
<td>Sig/Colonoscopy</td>
<td></td>
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<tr>
<td>Mammogram</td>
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<tr>
<td>Dental Exam</td>
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<tr>
<td>Pap Smear</td>
<td></td>
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<tr>
<td>Bone Density</td>
<td></td>
</tr>
<tr>
<td>Cholesterol</td>
<td></td>
</tr>
<tr>
<td>PSA</td>
<td></td>
</tr>
</tbody>
</table>

**Immunizations:**

- Tetanus
- Pneumonax
- Influenza
- Hepatitis A/B
- Other
Please check Symptoms you currently have or suffer from on a chronic basis:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
</table>

**X GENERAL**
- Chills/Sweats
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness/Poor Memory
- Headache
- Difficulty Sleeping
- Loss/Gain of weight
- Nervousness/Anxiety
- Fatigue
- Poor Concentration
- Temperature intolerance

**X MUSCLE/Joint/Bone**
- Pain, weakness, numbness in: Arms/Hands
- Legs/Feet
- Back/Hips
- Neck/Shoulders

**X SKIN**
- Bruise easily
- Hives
- Itching/dryness
- Changes in moles
- Rash
- Sore that won’t heal
- Nail changes

**X EYE, EAR, NOSE, THROAT**
- Vision disturbances
- Difficulty swallowing
- Earache
- Ear drainage
- Hay fever/allergies
- Hoarseness
- Loss of hearing
- Nosebleeds
- Sinus problems
- Dental problems
- Bleeding gums

**X GASTROINTESTINAL**
- Poor appetite
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive gas
- Excessive thirst
- Hemorrhoids
- Indigestion
- Nausea/Vomiting
- Stomach pain

**X CARDIOVASCULAR**
- Chest pain/discomfort
- High Blood Pressure
- Irregular Heart Beat
- Palpitations
- Poor circulation
- Swelling of ankles
- Varicose veins
- Exercise intolerance

**X MEN ONLY**
- Breast lump
- Erection difficulties
- Problems with sex life
- Lump in testicles
- Penis discharge
- Sore on penis
- Urinary dribbling
- Weak urinary flow

**X WOMEN ONLY**
- Abnormal pap smear
- Bleeding between periods
- Breast lump
- Breast pain
- Menstrual pain
- Menstrual pain
- Vaginal discharge
- Vaginal itching
- Premenstrual symptoms

**X PULMONARY**
- Persistent cough
- Cough up blood
- Shortness of breath
- Wheezing
- Night Sweats

**X OTHER**
- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination
- Frequent infection
- Kidney stone