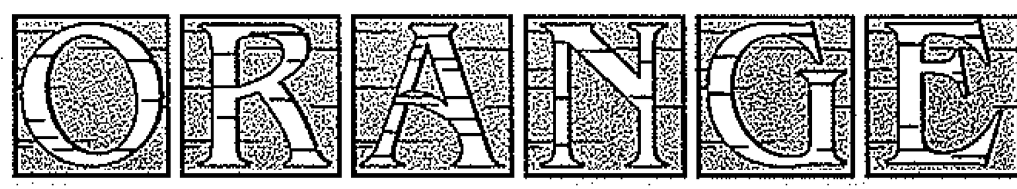

Date ____________________

Please answer the following questions. All information is confidential.

1. Name/current address ______________________________ 2. Sex ____ 3. Race ____________

4. Birthdate: ______________ 5. Place of Birth: ______________________________
City State

6. Home phone: ______________ 7. Other phone number: ______________________________

8. Where have you lived? ______________________________

9. How much education have you completed? ______________________________

10. Current marital status: ______________________

If married, date of marriage: ______________ Occupation of spouse: ______________________

11. Do you work outside of the home? ____ Yes ____ No

If yes, what do you do? ______________________ Hours: ______________________

Describe any hazards at work: ______________________________

12. Have you ever been in the military? ____ Yes ____ No

If yes, when? ______________________________

13. What do you feel are your major life stresses? ______________________________

____

14. Do you:

Smoke cigarettes?	____ Yes	____ No	If yes, _____ packs/day _____ years smoking	
Smoke cigars, pipe?	____ Regularly	____ Occasionally	____ Never	
Drink beer, wine, liquor?	____ Regularly	____ Occasionally	____ Never	
Exercise?	____ Regularly	____ Occasionally	____ Never	
Use any illegal drugs?	____ Regularly	____ Occasionally	____ Never	
Have a special diet?	____ Yes	____ No	If yes, please describe ______________	

15. What type of housing do you have (apartment, mobile home)? ______________________

Do you rent or own? __________ City or well water? __________

16. Who lives with you? ______________________________

17. Indicate each you have had and the last year you had it:

____ Physical Exam	____ Electrocardiogram	____ Pap Smear
____ Chest X-ray	____ Tetanus Shot	____ Flu Shot
____ TB (Tine) Skin Test	____ Blood Transfusion	____ Mammogram

18. Mark any past or present illnesses of yourself or family members:

Self	Family		Self	Family		Self	Family	
____	____	Alcoholism	____	____	Anemia	____	____	Cancer/tumor
____	____	Epilepsy	____	____	Gout	____	____	High blood pressure
____	____	Tuberculosis	____	____	Diabetes	____	____	Nervous breakdown
____	____	Ulcer	____	____	Heart trouble	____	____	Allergies or asthma
____	____	Glaucoma	____	____	Bleeding tendencies	____	____	Kidney/bladder trouble
____	____	Stroke	____	____	Rheumatism/arthritis	____	____	Other

19. What medicines are you taking? Include aspirin, birth control, etc.:

Medication	How Often	Reason

20. Additional medical information:

A. Any allergies to foods or medications: ______________________________

B. Any serious injuries (broken bones, accidents): ______________________________

____

____

____

21. Any past hospitalizations or operations:

Month/Year	Reason	Hospital, City, State

22. If you have been pregnant, how many times? ______________ How many children do you have? ______________

23. Describe your childbirths:

Month/Year	Birth Weight	Problems	Hospital, City, State

24. Symptom list: Place a check in front of any of the following body parts symptoms that are or have been a problem for you.

Circle the main problems for you now, if any.

A.
- _____ Rashes, color change
- _____ Itching, bruising
- _____ Worts, moles, lumps, hives
- _____ Skin trouble, eczema
- _____ Excessive sweating
- _____ Bleeding, anemia
- _____ Gland swelling

D.
- _____ Enlarged/painful breasts
- _____ Lumps, discharge from breasts
- _____ Poor appetite
- _____ Gas, cramps, pains
- _____ Heartburn, indigestion
- _____ Nausea, vomiting
- _____ Constipation, diarrhea
- _____ Blood in stool, hemorrhoids
- _____ Yellow jaundice, hernia

I.
- _____ Head injury, concussion
- _____ Headaches, migraine
- _____ Dizziness, fainting
- _____ Ear trouble, infection
- _____ Hearing loss, noises
- _____ Vision loss, double vision
- _____ Glasses, difficulty reading
- _____ Nosebleeds, stuffy nose
- _____ Sinus trouble, hayfever
- _____ Sore throats, hoarseness
- _____ Dental or gum problems
- _____ Goiter, thyroid problem

B.
- _____ Trouble swallowing
- _____ Poor appetite
- _____ Heartburn, indigestion
- _____ Nausea, vomiting
- _____ Constipation, diarrhea
- _____ Blood in stool, hemorrhoids
- _____ Yellow jaundice, hernia

E.
- _____ Chest pain, tightness, pressure
- _____ Swelling of feet or ankles
- _____ Fast or irregular heart burn
- _____ Heart trouble, murmurs
- _____ Trouble breathing lying down
- _____ High blood pressure
- _____ Awakening short of breath
- _____ Poor circulation
- _____ Blood clot, varicose veins

J. FOR WOMEN ONLY
- _____ Irregular/frequent periods
- _____ Excessive flow periods
- _____ Painful periods
- _____ Vaginal discharge, itching
- _____ Date of last menstrual period

C.
- _____ Shortness of breath
- _____ Cough, chest colds
- _____ Bringing up sputum or blood
- _____ Wheezing, asthma
- _____ Chest pain, pleurisy
- _____ Exposure to tuberculosis
- _____ Fever, sweats, chills

F.
- _____ Pain/burning on urination
- _____ Trouble starting/stopping urine
- _____ Blood or pus in urine
- _____ Frequent urinating
- _____ Sores or discharge

G.
- _____ Pains in joints, stiffness
- _____ Back pain, neck pain
- _____ Swollen/red joints, stiffness

H.
- _____ Convulsions, fits, spells
- _____ Shaking, weakness, tremor
- _____ Numbness, tingling, paralysis
- _____ Difficulty walking, coordination
- _____ Depression, anxiety
- _____ Poor sleeping
- _____ Nervousness, tension
- _____ Trouble thinking, remembering
- _____ Crying, upset, worrying
- _____ Sexual problems
- _____ Birth control type: ______________
- _____ Guilt about drinking, morning drinking
- _____ Trying to cut down on drinking
- _____ Family problems, poor social support

25. How did you hear about us: ❑ **Phone book** ❑ **Advertising-where advertised** ______________________________

❑ **Referral** ______________________ ❑ **Other** ______________________