

Within the recent past have you experienced any of the following symptoms? Check any that apply.

General

- chills
- fever
- sweats
- weight loss
- weight gain
- loss of sleep
- forgetfulness
- nervousness
- depression
- numbness
- dizziness
- fainting
- headache

Cardiovascular

- chest pain/pressure
- high blood pressure
- irregular heart beat
- ankle swelling
- varicose veins

Respiratory

- shortness of breath
- persistent cough
- sputum
- blood in sputum
- wheezing
- pain with breathing
- snoring

Gastrointestinal

- poor appetite
- bloating
- bowel changes
- constipation
- diarrhea
- hemorrhoids
- blood in stool
- rectal bleeding
- indigestion, reflux
or heartburn
- nausea
- vomiting
- abdominal pain
- vomiting blood

Genito-Urinary

- frequent urination
- blood in urine
- painful urination
- urination at night
- poor bladder control

Pain in any of these areas

- neck
- arms
- shoulders
- elbows
- wrists
- hands
- back
- hips
- legs
- ankles
- feet

Eyes

- blurred vision
- double vision
- vision – halos
- vision – flashes

Skin

- rash
- hives
- changing moles
- itching
- easy bruising
- sores that won't heal

Ear/Nose/Throat

- earache
- poor hearing
- use hearing aide(s)
- ringing in ears
- ear discharge
- sinus congestion
- nosebleeds
- bleeding gums
- frequent sore throat
- painful swallowing
- hoarseness
- swollen glands

WOMEN ONLY

- breast lump
- previous abnormal
Mammogram
- previous breast biopsy
- abnormal Pap smear
- irregular bleeding
- severe cramps
- hot flashes
- painful intercourse
- vaginal discharge
- nipple discharge
- other:

Last period _____

Are you pregnant? _____

Number of pregnancies _____

Number of live births _____

MEN ONLY

- erection difficulties
- lump in testicle
- sore on penis
- discharge from the penis
- other:

EXERCISE

- Check all that apply:
- I exercise regularly
 - My job keeps me physically
active and fit
 - I enjoy exercise
 - I am unable to exercise due
to physical problems
 - I would like to discuss
exercise

TOBACCO

- I smoke cigarettes
- packs per day
- I am ready to quit
smoking
- I use other forms of
Tobacco

I consume alcohol:

- never
- less than once a week
- one or more times
each week
- daily or almost daily
- I am trying to cut back
- I get annoyed when
people criticize my drinking
- I feel guilty about my
drinking
- A drink in the morning gets
me going or steadies my
nerves.

FOR THOSE OVER 70:

I have a living will

In the past 6 months I
have fallen one or more times

I have difficulty doing the
following:

- remembering things
- driving
- driving at night
- managing my finances
- caring for my spouse
- meal preparation
- taking medication
- bathing
- walking without help

List any medications that you are allergic to or otherwise unable to take:

In the past month

___ I have felt down, depressed or hopeless and I had trouble shaking the feeling

___ I took little pleasure in the things I enjoy the most

If you answered yes to either of these questions please continue by checking the appropriate boxes:

	Not at all	Several days	More than half the days	Nearly every day
I have had little interest in doing things				
I have felt down, depressed or hopeless				
I have had trouble falling or staying asleep or sleeping too much				
I have felt tired and had little energy				
I have had poor appetite or have been overeating				
I have felt bad about myself or felt that I let myself or my family down				
I have had trouble concentrating on TV or reading				
I have been moving slowly or have been fidgety or restless				
I have thought that I might be better off dead				

These symptoms have made it difficult for me at work, or getting along with people or taking care of things at home: ___ Not at all; ___ Somewhat; ___ very much; ___ extremely so.

Prevention and Screening Procedures

Procedure	Have you undergone?	Date of last	Would you like to discuss?
Pap Smear			
Mammogram			
Colonoscopy			
Other test for colon cancer			
Prostate cancer blood test-PSA			
Bone mineral density test			
Influenza immunization			
Pneumonia immunization			
Tetanus immunization			
Testing for HIV/AIDS**			
Testing for Hepatitis C*			

*recommended if you have ever used (even a single experiment) intravenous drugs or you received a blood transfusion or solid organ transplant before July 1992. **The Centers for Disease Control recommends testing of all people 13-64 years of age

My Family Health History

I am adopted and unaware of parental medical history

Your Family	Alive ?		Complete one of the following:		Comments
	Yes – List age	No- List age at time of death	If alive, Current Health	If deceased, Cause of Death	
Mother					
Father					
Brothers					
Sisters					
Children					

In answering the following questions consider parents, brothers, sisters, children, grandparents, aunts, uncles and cousins. If any answer is affirmative list the type of relations. For example if any family members have diabetes you might list “mother, father, 1 brother”.

Does any member of your family have the following?

- | | |
|------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Sudden death in someone who appeared to be well |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Severe visual loss before the age of 55 |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Severe hearing loss before the age of 60 |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Prostate cancer | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Colon or rectal cancer | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Colon polyps | |
| <input type="checkbox"/> Breast cancer | |
| <input type="checkbox"/> Endometrial (uterus) cancer | |
| <input type="checkbox"/> Melanoma | |
| <input type="checkbox"/> Thyroid cancer | |
| <input type="checkbox"/> Other cancer | |

Miscellaneous: Please list any other issues you would like to discuss: