NAME:_____

DATE:_____

Please complete the following questionaire. This will help us properly address the issues important to your health.

Please list the purpose of your visit:_____

_____

What are your present health concerns:_____

_____

Medical History

Are you presently receiving medical treatment for any condition(s)? YES NO

If yes please list condition(s)

Condition	How Long

Medications

Please list any medications you take regularly such as prescription, non-prescription, vitamins, home remedies, birth control pills or herbs.

Medications	How may times a day	How Long

Allergies

Are you allergic to any medication? (If yes, please list below) YES NO

Are you allergic to any food or substances? (If yes, please list below) YES NO

Allergic To:

_____

Do you have any of the following?

	Yes	No		Yes	No
Seen a dentist in the last year			Feel to hot or too cold		
Wear Dentures			Tremors or shaking of hands		
Gums bleed easily			Chills or night sweats		
Persistent sores on lips or tongue			Treatment by X-ray or radiation		
Persistent change in sense of taste/smell			Frequent nausea or vomiting		
Frequent or sever sore throat			Stomach pain		
Hoarseness that last more than 1 week			Excessive gas belching or bloating		
Colds usually go to chest			Intolerance of fatty food		
Wheezy or whistling chest			Recent change in bowel habits		
Chronic cough			Diarrhea lasting more than one week		
Cough up blood			Blood in bowel movements		
Short of breath			Black or tarry bowel movements		
Chest Pain			Constipation		
Pressure or heaviness in chest			Get up at night to urinate		
Chest pain which radiated down arm			Trouble starting stream when you urinate		
Irregular heartbeat			Loss of force when you urinate		
Abnormal EKG			Burning or pain when you urinate		
Ankles swell			Swelling of joints		
Sleep propped up in bed			Frequent backaches		
Pain in either leg on walking			Persistent numbness in any body part		
Difficulty swallowing			Any other problems you want to discuss		

Women Only

Number of times pregnant			Unexplained vaginal bleeding		
Now pregnant			Unusual or excessive vaginal discharge		
Number of miscarriages or abortions			Pap Smear in the last year		
Lump in breasts			Menopause		
Discharge or bleeding from nipples			Date of Last Period		
Examine you breasts at least monthly			Regular Periods		
			Severe cramps during periods		

When were your most recent Screening Test:	**Date**	**Results**
Lipid		
Stool test for Occult Blood		
Sigmoidoscopy		
Mammogram Ever Abnormal		
Pap Smear Ever Abnormal		

Family History:

Has any blood relative ever had?

Cancer	Yes	No
Heart Disease	Yes	No
Hypertension	Yes	No
Glaucoma	Yes	No
Diabetes	Yes	No
Committed Suicide	Yes	No
Emotions, nervous, or mental breakdown	Yes	No

If you answered "Yes" to any of the above please specify relationship & problem below:

Relationship	Age	Medical Problem	Cause of Death	Age at Death

Smoking

Have you ever smoked?	Yes	No
If yes, at what age did you start?_____		
Do you smoke now?	Yes	No
If no, at what age did you stop?_____		

Fill in the appropriate columns?

Quantity	Present	When you stopped
Cigarettes (no. a day)		
Cigars (no. a day)		
Pipe (pipefuls a day)		

Alcohol Intake

Do you drink alcoholic beverages?	Yes	No
Did you ever drink alcohol but stop?	Yes	No
Do you consider yourself a normal drinker?	Yes	No
Are you always able to stop drinking when you want?	Yes	No
Has drinking ever created a problem for your job or family?	Yes	No
Have you ever gone to anyone for help about your drinking?	Yes	No

Quantity	Present	When you stopped
Liquor (ounces/week)		
Beer (bottles/week)		
Wine (glasses/week)		

Other Substance Use

Have you ever used illicit or illegal drugs?	Yes	No
Do you presently use illicit or illegal drugs?	Yes	No