



5. Check any of the following diseases you have had:

<b>DISEASE</b>		<b>AGE</b>	<b>DISEASE</b>		<b>AGE</b>
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>
<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>
<input type="checkbox"/>	Ulcer (Stomach)	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
<input type="checkbox"/>	Ulcer (Duodenum)	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>
<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>			

Comments:

6. Have you ever been troubled or are you troubled now by any of the following:

<b>NOW</b>	<b>PAST</b>		<b>NOW</b>	<b>PAST</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic Pain	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Chest
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	Other Heart Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Blood With Cough
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Chest X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling Hands/Feet	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Comments:

7. Have you ever been troubled or are you troubled now by any of the following:

<b>NOW</b>	<b>PAST</b>		<b>NOW</b>	<b>PAST</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight change	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent abdominal pain
<input type="checkbox"/>	<input type="checkbox"/>	Tarry (black) stools	<input type="checkbox"/>	<input type="checkbox"/>	Changes in bowel habits
<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Difficult/painful urination
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Palpitation of heart
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Balance problems
<input type="checkbox"/>	<input type="checkbox"/>	Frequent nausea & vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Sexual difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Discomfort in chest w/exertion	<input type="checkbox"/>	<input type="checkbox"/>	Infertility
<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles & legs	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding or bruising
<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	<input type="checkbox"/>	Suicidal idea	<input type="checkbox"/>	<input type="checkbox"/>	Difficulties w/memory from recent events
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged lymph nodes in:			
		<input type="checkbox"/> Neck			
		<input type="checkbox"/> Armpits			
		<input type="checkbox"/> Groin			

Comments:

**FOR WOMEN ONLY**

NOW	PAST	
___	___	History of STD
___	___	Vaginal itch
___	___	Vaginal bleeding or discharge not part of periods

**FOR MEN ONLY**

NOW	PAST	
___	___	Impotence
___	___	History of STD
___	___	Sores/discharge from penis

Comments:

- 8. Are you currently pregnant? \_\_\_\_\_
- 9. When was your last period? \_\_\_\_\_
- 10. Do you have any problems associated with your menstrual cycle? \_\_\_\_\_
- 11. How much tobacco do you use and in what form? \_\_\_\_\_
- 12. How long have you smoked/used tobacco? \_\_\_\_\_
- 13. If you once used tobacco but do not currently use it, how long has it been since you used it? \_\_\_\_\_
- 14. On average, how many alcoholic beverages do you consume per week? \_\_\_\_\_
- 15. Family history of serious illness. Are there any diseases that occur often in your family? \_\_\_\_\_

16. Please list all serious accidents you have had and the age they happened.

ACCIDENT INJURY

AGE

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

17. Have you ever been treated for emotional problems? If yes, please indicate by whom and when.

\_\_\_\_\_

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\_\_\_\_\_