

I currently have severe fatigue, tiredness or exhaustion: Yes No

	Y	N
I often:		
awaken tired after adequate sleep	<input type="radio"/>	<input type="radio"/>
fall asleep at inappropriate times	<input type="radio"/>	<input type="radio"/>
am anxious or nervous	<input type="radio"/>	<input type="radio"/>
am worried about being ill	<input type="radio"/>	<input type="radio"/>
am irritable	<input type="radio"/>	<input type="radio"/>
feel like crying	<input type="radio"/>	<input type="radio"/>
feel hopeless or down in the dumps	<input type="radio"/>	<input type="radio"/>
have problems with depression	<input type="radio"/>	<input type="radio"/>
feel suicidal	<input type="radio"/>	<input type="radio"/>
have attacks of feeling panicked	<input type="radio"/>	<input type="radio"/>

	Y	N
I have:		
problems controlling anger	<input type="radio"/>	<input type="radio"/>
difficulty caring for myself	<input type="radio"/>	<input type="radio"/>
frequent headaches	<input type="radio"/>	<input type="radio"/>
trouble falling or staying asleep	<input type="radio"/>	<input type="radio"/>

Do you have an Advanced Directive (Living Will, Durable Power of Attorney for Health Care, or Directive to Physicians)?	<input type="radio"/>	<input type="radio"/>
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NEUROLOGIC

	Y	N
Do you had or do you have:		
trouble with your balance?	<input type="radio"/>	<input type="radio"/>
a fall within the past year?	<input type="radio"/>	<input type="radio"/>
trouble walking?	<input type="radio"/>	<input type="radio"/>
trouble remembering?	<input type="radio"/>	<input type="radio"/>
problems with dizziness?	<input type="radio"/>	<input type="radio"/>
ever been knocked unconscious?	<input type="radio"/>	<input type="radio"/>
involuntary movements of your body?	<input type="radio"/>	<input type="radio"/>
a convulsion or seizure?	<input type="radio"/>	<input type="radio"/>
	Y	N

numbness in your hands or feet?	<input type="radio"/>	<input type="radio"/>
hand/foot paralysis for >5 min?	<input type="radio"/>	<input type="radio"/>
a temporary loss of speech?	<input type="radio"/>	<input type="radio"/>
a temporary loss of vision ?	<input type="radio"/>	<input type="radio"/>
a stroke?	<input type="radio"/>	<input type="radio"/>
hallucinations at times?	<input type="radio"/>	<input type="radio"/>
a nervous breakdown?	<input type="radio"/>	<input type="radio"/>
a brain, nerve, or emotional problem not on this list?	<input type="radio"/>	<input type="radio"/>

EYES

	Y	N
Have you had or do you have:		
blurry vision?	<input type="radio"/>	<input type="radio"/>

double vision? (not blurred)	<input type="radio"/>	<input type="radio"/>
	Y	N

visual spots / floaters?	<input type="radio"/>	<input type="radio"/>		
color blindness?	<input type="radio"/>	<input type="radio"/>		<input type="radio"/> Y <input type="radio"/> N
A spot in your vision?	<input type="radio"/>	<input type="radio"/>	cataracts?	<input type="radio"/> O <input type="radio"/> O
	<input type="radio"/> Y	<input type="radio"/> N	a retinal hemorrhage?	<input type="radio"/> O <input type="radio"/> O
A sudden loss of vision?	<input type="radio"/>	<input type="radio"/>	macular degeneration?	<input type="radio"/> O <input type="radio"/> O
A blind eye?	<input type="radio"/>	<input type="radio"/>	a detached retina?	<input type="radio"/> O <input type="radio"/> O
a glass eye?	<input type="radio"/>	<input type="radio"/>	glaucoma?	<input type="radio"/> O <input type="radio"/> O
itchy eyes?	<input type="radio"/>	<input type="radio"/>	an eye problem not on this list?	<input type="radio"/> O <input type="radio"/> O
eye pain?	<input type="radio"/>	<input type="radio"/>		

EARS

	<input type="radio"/> Y	<input type="radio"/> N		<input type="radio"/> Y <input type="radio"/> N
Have you had or do you have:				
trouble hearing?	<input type="radio"/>	<input type="radio"/>	frequent ear infections?	<input type="radio"/> O <input type="radio"/> O
prolonged exposure to loud noise?	<input type="radio"/>	<input type="radio"/>	a draining ear?	<input type="radio"/> O <input type="radio"/> O
tinnitus (ringing) in your ears?	<input type="radio"/>	<input type="radio"/>	a serious ear injury?	<input type="radio"/> O <input type="radio"/> O
a hearing aid that you use?	<input type="radio"/>	<input type="radio"/>	an ear problem not on this list?	<input type="radio"/> O <input type="radio"/> O

NOSE/SINUSES

	<input type="radio"/> Y	<input type="radio"/> N		
Have you had or do you have:				<input type="radio"/> Y <input type="radio"/> N
hay fever or allergic rhinitis?	<input type="radio"/>	<input type="radio"/>	frequent nose bleeds?	<input type="radio"/> O <input type="radio"/> O
frequent sneezing, nasal watering or nasal congestion?	<input type="radio"/>	<input type="radio"/>	nasal polyps?	<input type="radio"/> O <input type="radio"/> O
mucus often draining from your nose?	<input type="radio"/>	<input type="radio"/>	nasal problem not on this list?	<input type="radio"/> O <input type="radio"/> O

MOUTH, THROAT, NECK

	<input type="radio"/> Y	<input type="radio"/> N		
Have you had or do you have a:				
lip problem?	<input type="radio"/>	<input type="radio"/>	swallowing problem?	<input type="radio"/> O <input type="radio"/> O
tooth or gum problem?	<input type="radio"/>	<input type="radio"/>	voice problem?	<input type="radio"/> O <input type="radio"/> O
mouth, tongue, or jaw problem?	<input type="radio"/>	<input type="radio"/>		<input type="radio"/> Y <input type="radio"/> N
thyroid disease?	<input type="radio"/>	<input type="radio"/>	problem with back of your throat?	<input type="radio"/> O <input type="radio"/> O
			lump or swelling in neck?	<input type="radio"/> O <input type="radio"/> O
			neck pain?	<input type="radio"/> O <input type="radio"/> O

a mouth, throat, or neck problem not
on this list?

LUNGS

	Y	N		Y	N
Have you had or do you have:					
wheezing?	<input type="radio"/>	<input type="radio"/>	I have been a cigarette smoker	<input type="radio"/>	<input type="radio"/>
Shortness of breath?	<input type="radio"/>	<input type="radio"/>	if yes, do you currently smoke?	<input type="radio"/>	<input type="radio"/>
A chronic cough?	<input type="radio"/>	<input type="radio"/>	If yes, how many cigarettes do you smoke now		
coughing up blood in the past year?	<input type="radio"/>	<input type="radio"/>	every day? _____		
Asthma?	<input type="radio"/>	<input type="radio"/>	If yes, how many years have you smoked? _____		
Emphysema?	<input type="radio"/>	<input type="radio"/>	I have used other tobacco products	<input type="radio"/>	<input type="radio"/>
Repeated episodes of pneumonia?	<input type="radio"/>	<input type="radio"/>	if yes, which ones: <input type="radio"/> cigars <input type="radio"/> pipe <input type="radio"/> snuff		
Tuberculosis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> chewing tobacco		
Pulmonary embolism (blood clot lung)?	<input type="radio"/>	<input type="radio"/>	are you currently using any of these?	<input type="radio"/>	<input type="radio"/>
Chronic bronchitis?	<input type="radio"/>	<input type="radio"/>	If yes, how many times per day? _____		
Collapsed lung?	<input type="radio"/>	<input type="radio"/>	I have:		
Sarcoid?	<input type="radio"/>	<input type="radio"/>	received BCG vaccine		
Frequent night sweats?	<input type="radio"/>	<input type="radio"/>	(TB immunization)	<input type="radio"/>	<input type="radio"/>
A lung or chest problem not listed?	<input type="radio"/>	<input type="radio"/>	had a positive TB skin test	<input type="radio"/>	<input type="radio"/>
			taken INH for at least 6 months	<input type="radio"/>	<input type="radio"/>
			received Pneumovax (pneumonia shot)	<input type="radio"/>	<input type="radio"/>

CARDIOVASCULAR

	Y	N		Y	N
Have you had or do you have:					
high blood pressure?	<input type="radio"/>	<input type="radio"/>	a heart attack for which you were		
a cholesterol problem?	<input type="radio"/>	<input type="radio"/>	hospitalized more than three days?	<input type="radio"/>	<input type="radio"/>
a heart valve problem?	<input type="radio"/>	<input type="radio"/>	a "clot buster" treatment for a		
an abnormal treadmill test?	<input type="radio"/>	<input type="radio"/>	heart attack?	<input type="radio"/>	<input type="radio"/>
a coronary arteriogram?	<input type="radio"/>	<input type="radio"/>	varicose veins?	<input type="radio"/>	<input type="radio"/>
angina pectoris (heart pains)?	<input type="radio"/>	<input type="radio"/>	narrowing of the arteries in your neck?	<input type="radio"/>	<input type="radio"/>
a silent heart attack?	<input type="radio"/>	<input type="radio"/>	a heart or circulatory problem not		
congestive heart failure?	<input type="radio"/>	<input type="radio"/>	listed here?	<input type="radio"/>	<input type="radio"/>
abnormal blood clot formation?	<input type="radio"/>	<input type="radio"/>			

	Y	N		Y	N
Do you get:					
pressure or tightness in your chest, with exertion or walking uphill?	<input type="radio"/>	<input type="radio"/>	episodes of rapid/irregular heartbeat?	<input type="radio"/>	<input type="radio"/>
pain in the legs that forces you to stop walking?	<input type="radio"/>	<input type="radio"/>	have you ever had abnormal blood clots develop?	<input type="radio"/>	<input type="radio"/>

SKIN

	Y	N		Y	N
I have:					
a mole that has changed color or size	<input type="radio"/>	<input type="radio"/>	allergy to cosmetics or chemicals	<input type="radio"/>	<input type="radio"/>
a sore that doesn't heal	<input type="radio"/>	<input type="radio"/>	allergy to medications	<input type="radio"/>	<input type="radio"/>
acne	<input type="radio"/>	<input type="radio"/>	If yes, please list _____		
eczema	<input type="radio"/>	<input type="radio"/>	history of radiation treatment	<input type="radio"/>	<input type="radio"/>
psoriasis	<input type="radio"/>	<input type="radio"/>	darkening of the skin	<input type="radio"/>	<input type="radio"/>
allergy to sunlight	<input type="radio"/>	<input type="radio"/>	a skin condition not listed	<input type="radio"/>	<input type="radio"/>

DIGESTIVE

	Y	N		Y	N
During the last year I have had:					
distinct weight gain or loss	<input type="radio"/>	<input type="radio"/>	inability to control my bowels	<input type="radio"/>	<input type="radio"/>
trouble swallowing	<input type="radio"/>	<input type="radio"/>	a digestion problem not on this list	<input type="radio"/>	<input type="radio"/>
indigestion or heartburn	<input type="radio"/>	<input type="radio"/>	I have been diagnosed by a doctor with:		
recurrent nausea or vomiting	<input type="radio"/>	<input type="radio"/>	esophagitis or esophageal reflux	<input type="radio"/>	<input type="radio"/>
During the last year I have had:			hiatal hernia	<input type="radio"/>	<input type="radio"/>
recurrent abdominal pain	<input type="radio"/>	<input type="radio"/>	liver trouble	<input type="radio"/>	<input type="radio"/>
an episode of vomiting blood	<input type="radio"/>	<input type="radio"/>	gallbladder problems	<input type="radio"/>	<input type="radio"/>
a change in bowel habits	<input type="radio"/>	<input type="radio"/>	peptic ulcer	<input type="radio"/>	<input type="radio"/>
frequent diarrhea	<input type="radio"/>	<input type="radio"/>	gastrointestinal bleeding	<input type="radio"/>	<input type="radio"/>
chronic constipation	<input type="radio"/>	<input type="radio"/>	irritable bowel syndrome	<input type="radio"/>	<input type="radio"/>
visible blood in bowel movement	<input type="radio"/>	<input type="radio"/>	intestinal polyps	<input type="radio"/>	<input type="radio"/>
black, tar-like, bowel movements	<input type="radio"/>	<input type="radio"/>	abdominal hernia (rupture)	<input type="radio"/>	<input type="radio"/>
	Y	N		Y	N

I have been diagnosed by a doctor with:

- hemochromatosis Y N
- hepatitis
- diabetes or borderline diabetes
- a gastrointestinal problem not on the list

In the past 10 years I have had a:

- barium enema
- colonoscopy
- sigmoidoscopy

I am:

- a vegetarian
- a strict vegetarian who also avoids fish and dairy
- likely to have some form of alcohol:
 never hardly ever < 3 times a week
 > three times per week daily

I sometimes wonder if I drink more than is good for me

Was there ever a time when you often drank five or more drinks a day of any kind of alcoholic beverage?

SURGERY

Have you had any of the following surgical operations:

- prostate surgery? Y N
- vasectomy?
- breast biopsy?
- lumpectomy?
- mastectomy?
- breast implants?
- tubal ligation?
- hysterectomy?
- bladder surgery?
- abdominal aortic aneurysm?
- angioplasty?
- appendectomy?
- cholecystectomy (gallbladder)?

- eye or ear surgery?
- heart valve replacement?
- hernia repair?
- kidney surgery?
- peptic ulcer surgery?
- thyroid surgery?
- artificial joint implant?
- disc or other back surgery?
- other bone surgery?
- surgery not on this list?

Have you ever been diagnosed with the following cancers?

- lung?
- blood or lymphatic?
- bladder?
- colon?
- skin?
- breast?

Have you had any of the following surgical operations:

- coronary bypass?
- carpal tunnel release?
- Y N**

cervix?	<input type="radio"/>	<input type="radio"/>	testicle?	<input type="radio"/>	<input type="radio"/>
uterus?	<input type="radio"/>	<input type="radio"/>	prostate?	<input type="radio"/>	<input type="radio"/>
ovary?	<input type="radio"/>	<input type="radio"/>	Any other cancer? _____		
	Y	N			

MUSCULOSKELETAL

	Y	N		Y	N
I have had:			a musculoskeletal problem not on this list		
a leg fracture	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
a fracture of the pelvis	<input type="radio"/>	<input type="radio"/>	I have been diagnosed with:		
a fracture other than listed	<input type="radio"/>	<input type="radio"/>	rheumatoid arthritis	<input type="radio"/>	<input type="radio"/>
a bone or ligament injury that never healed	<input type="radio"/>	<input type="radio"/>	osteoarthritis	<input type="radio"/>	<input type="radio"/>
polio	<input type="radio"/>	<input type="radio"/>	psoriatic arthritis	<input type="radio"/>	<input type="radio"/>
I currently have:			other forms of arthritis	<input type="radio"/>	<input type="radio"/>
night time leg cramps	<input type="radio"/>	<input type="radio"/>	osteoporosis	<input type="radio"/>	<input type="radio"/>
pain or stiffness in my joints on most days	<input type="radio"/>	<input type="radio"/>	lupus	<input type="radio"/>	<input type="radio"/>
			fibrositis or fibromyalgia	<input type="radio"/>	<input type="radio"/>

MEN'S HEALTH

	Y	N		Y	N
I have had:			pain or burning with urination	<input type="radio"/>	<input type="radio"/>
prostatitis	<input type="radio"/>	<input type="radio"/>	blood in urine	<input type="radio"/>	<input type="radio"/>
a kidney stone	<input type="radio"/>	<input type="radio"/>	problems getting an erection	<input type="radio"/>	<input type="radio"/>
I currently have:			problem with impotence or maintaining an erection during sex	<input type="radio"/>	<input type="radio"/>
problem starting or stopping urine	<input type="radio"/>	<input type="radio"/>	a urinary, sexual, or men's health problem not on this list	<input type="radio"/>	<input type="radio"/>
occasional loss of urine	<input type="radio"/>	<input type="radio"/>			
reduced urine strain	<input type="radio"/>	<input type="radio"/>			
to get up several times each night to urinate	<input type="radio"/>	<input type="radio"/>			

WOMEN'S HEALTH

	Y	N
I have a:		
lump in my breast	<input type="radio"/>	<input type="radio"/>
nipple discharge	<input type="radio"/>	<input type="radio"/>
problem with breast tenderness or pain	<input type="radio"/>	<input type="radio"/>
has your physician ever recommended that you have a mammogram?	<input type="radio"/>	<input type="radio"/>
My last mammogram was _____		

How often do you do your own breast exam? _____

I have had:		
a breast biopsy or aspiration that was NOT cancer	<input type="radio"/>	<input type="radio"/>
a lumpectomy for cancer	<input type="radio"/>	<input type="radio"/>
a mastectomy for cancer	<input type="radio"/>	<input type="radio"/>
fibrocystic breast diagnosis	<input type="radio"/>	<input type="radio"/>
a breast problem not on the list	<input type="radio"/>	<input type="radio"/>

I have:		
vaginal itching	<input type="radio"/>	<input type="radio"/>
a vaginal discharge	<input type="radio"/>	<input type="radio"/>
vaginal dryness	<input type="radio"/>	<input type="radio"/>
pain with intercourse	<input type="radio"/>	<input type="radio"/>
chronic pelvic pain	<input type="radio"/>	<input type="radio"/>

I am:		
currently pregnant	<input type="radio"/>	<input type="radio"/>
still having menstrual periods	<input type="radio"/>	<input type="radio"/>
definitely in menopause	<input type="radio"/>	<input type="radio"/>
not certain about my present state	<input type="radio"/>	<input type="radio"/>

I currently have:		
no periods	<input type="radio"/>	<input type="radio"/>
regular periods	<input type="radio"/>	<input type="radio"/>
irregular periods	<input type="radio"/>	<input type="radio"/>

	Y	N
heavy periods	<input type="radio"/>	<input type="radio"/>
a lot of pain with my periods	<input type="radio"/>	<input type="radio"/>
bleeding or spotting between periods	<input type="radio"/>	<input type="radio"/>
vaginal spotting after I thought menopause had started	<input type="radio"/>	<input type="radio"/>

I have:		
loss of urine	<input type="radio"/>	<input type="radio"/>
pain or burning with urination	<input type="radio"/>	<input type="radio"/>
had blood in my urine	<input type="radio"/>	<input type="radio"/>
to urinate frequently	<input type="radio"/>	<input type="radio"/>
repeated urinary infections	<input type="radio"/>	<input type="radio"/>
a urinary problem not on this list	<input type="radio"/>	<input type="radio"/>

I have had:		
an infected tube, PID, or other pelvic infection	<input type="radio"/>	<input type="radio"/>
glomerulonephritis	<input type="radio"/>	<input type="radio"/>
ectopic pregnancy	<input type="radio"/>	<input type="radio"/>
a kidney stone	<input type="radio"/>	<input type="radio"/>
pyelonephritis	<input type="radio"/>	<input type="radio"/>
my last Pap smear was _____		
what type of birth control do you currently use _____		

how many pregnancies have you had _____

how many births have you had _____

I have had:		
reproductive, urinary, or sexual problems that are not mentioned	<input type="radio"/>	<input type="radio"/>
abnormal blood clots during pregnancy	<input type="radio"/>	<input type="radio"/>
other abnormal blood clots in the past	<input type="radio"/>	<input type="radio"/>
to be taken off the pill because of clotting problems	<input type="radio"/>	<input type="radio"/>

FAMILY HISTORY

I am:	Y	N	
adopted	<input type="radio"/>	<input type="radio"/>	I have _____ brothers
an identical twin	<input type="radio"/>	<input type="radio"/>	I have _____ sisters
One of my children has serious health or emotional problems	<input type="radio"/>	<input type="radio"/>	
Some primary members of my family died before age 65	<input type="radio"/>	<input type="radio"/>	

Please check any appropriate boxes. **The following have occurred in my biologic family:**

	Mother	Father	Brothers	Sisters	Children	Grandparents
Heart attack						
High blood pressure						
Diabetes						
Cancer						
Stroke						
Abnormal blood clots						
Alcoholism						
Illegal or street drug use						
Liver problems						
Any rare hereditary disease						
Depression						
Suicide						
Serious health or emotional problem						
If deceased, please write the age in which they died						

SOCIAL/SEXUAL HISTORY

Important: This information is **confidential**. It will be placed in a section of your medical chart that cannot be duplicated if your medical record is ever copied for health companies, employers, etc. This information is helpful for your medical treatment, but if you do not feel comfortable filling out any section, you may leave it blank.

	Y	N		Y	N
I am:			I have:		
a virgin	<input type="radio"/>	<input type="radio"/>	been physically abused as a child	<input type="radio"/>	<input type="radio"/>
not sexually active within the past year	<input type="radio"/>	<input type="radio"/>	been verbally abused as a child	<input type="radio"/>	<input type="radio"/>
no longer sexually active	<input type="radio"/>	<input type="radio"/>	been sexually molested as a child or adolescent	<input type="radio"/>	<input type="radio"/>
sexually active with a male partner	<input type="radio"/>	<input type="radio"/>	been raped	<input type="radio"/>	<input type="radio"/>
sexually active with a female partner	<input type="radio"/>	<input type="radio"/>	been threatened or abused as an adult by a sexual partner	<input type="radio"/>	<input type="radio"/>
sexually active with more than one partner at this time	<input type="radio"/>	<input type="radio"/>	Has your partner ever threatened, pushed, or shoved you?	<input type="radio"/>	<input type="radio"/>
satisfied with my sex life	<input type="radio"/>	<input type="radio"/>	Have you ever threatened, pushed, or shoved your partner?	<input type="radio"/>	<input type="radio"/>
I am:			Have you ever had a partner threaten or abuse your children?	<input type="radio"/>	<input type="radio"/>
possibly at risk for AIDS	<input type="radio"/>	<input type="radio"/>			
diagnosed with HIV/AIDS	<input type="radio"/>	<input type="radio"/>	I am having serious problems with:		
I have had:			my marriage	<input type="radio"/>	<input type="radio"/>
urethritis	<input type="radio"/>	<input type="radio"/>	my family	<input type="radio"/>	<input type="radio"/>
genital herpes	<input type="radio"/>	<input type="radio"/>	my job	<input type="radio"/>	<input type="radio"/>
gonorrhea	<input type="radio"/>	<input type="radio"/>	finances	<input type="radio"/>	<input type="radio"/>
syphilis	<input type="radio"/>	<input type="radio"/>	drug or alcohol use	<input type="radio"/>	<input type="radio"/>
a sexually transmitted disease not on this list	<input type="radio"/>	<input type="radio"/>	work-related injuries	<input type="radio"/>	<input type="radio"/>
			have you ever used street drugs, even one time?	<input type="radio"/>	<input type="radio"/>