

III. Medications (including aspirin):

Dosage

Frequency

- 1. _____
- 2. _____
- 3. _____
- 4. _____

IV. Allergies? (to any medicine or tapes?)

- 1. _____ 3. _____
- 2. _____ 4. _____

V. Injuries (describe briefly)

- 1. _____ 2. _____

VI. Family History

	Living	Deceased	Illnesses	Cause of Death/Age
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister(s) # _____	<input type="checkbox"/>	# _____	_____	_____
Brother(s) # _____	<input type="checkbox"/>	# _____	_____	_____

VII. Family History of Following:

	Yes	No		Yes	No
1. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
2. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	6. Gastrointestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
3. Prostate Disease	<input type="checkbox"/>	<input type="checkbox"/>	7. Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
4. Cancer(s)	<input type="checkbox"/>	<input type="checkbox"/>	8. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

VIII. Social Habits:

	Yes	No	Amount
1. Do You Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Do You Drink Alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Any Caffeine Use?			
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sodas	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Any Blood Transfusions?	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____

IX. Do you have any of these symptoms?

1. Const. .	yes	no	7. Musculo-skeletal	yes	no
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Wt. loss	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	8. Integumentary		
2. Eyes			Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>
Vision blurring	<input type="checkbox"/>	<input type="checkbox"/>	9. Neurological		
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
3. ENT			Strokes	<input type="checkbox"/>	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>	10. Psychiatric		
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	Change in personality	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	11. Endocrine		
4. Cardiovascular			Intolerance to heat	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Intolerance to cold	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Constant thirst	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>	12. Hematologic/Lymphatic		
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	Lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>
5. Resp.			Bruisability	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	13. Allergic/Immunology		
Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Breathing difficulty	<input type="checkbox"/>	<input type="checkbox"/>			
6. GI					
Nausea	<input type="checkbox"/>	<input type="checkbox"/>			
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>			
Belly pain	<input type="checkbox"/>	<input type="checkbox"/>			
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			
Blood stool	<input type="checkbox"/>	<input type="checkbox"/>			

REVIEWED BY _____