Please use additional sheets as needed to explain answers.

ALLERGIES

ARE YOU ALLERGIC TO...	NO	YES	IF YES, EXPLAIN:
Medications			
Environmental (molds, dust, toxins)			
Foods			

SURGERY

HAVE YOU HAD SURGERY...	NO	YES	IF YES, EXPLAIN:	DATES
Any In- or Out-Patient Surgery:				
Ever Had a Transfusion?				
Any Hospitalization?				

SYSTEMS

DO YOU NOW HAVE OR HAVE YOU EVER HAD...	YES	DO YOU NOW HAVE OR HAVE YOU EVER HAD...	YES
Any ❑ Eye Disease ❑ Eye Injury ❑ Impaired Sight		Kidney ❑ Disease ❑ Stones	
Any ❑ Ear Disease ❑ Ear Injury ❑ Impaired Hearing		Bladder Disease	
Any Trouble with ❑ Nose ❑ Sinuses ❑ Mouth ❑ Throat		Blood in Urine	
Fainting Spells		❑ Albumin ❑ Sugar ❑ Pus ❑ Etc. in Urine	
Convulsions		Difficulty in Urination	
Paralysis		Narrowed Urinary Stream	
Dizziness		Abnormal Thirst	
Headaches: ❑ Frequent ❑ Severe		Prostate Trouble	
Enlarged Glands		❑ Stomach Trouble ❑ Ulcer	
Thyroid: ❑ Overactive ❑ Underactive ❑ Enlarged		Indigestion	
Enlarged Goiter		❑ Gas ❑ Belching	
Skin Disease		Appendicitis	
Cough: ❑ Frequent ❑ Chronic		❑ Liver Disease ❑ Gall Bladder Disease	
❑ Chest Pain ❑ Angina Pectoris		❑ Colitis ❑ Other Bowel Disease	
Spitting Up Blood		❑ Hemorrhoids ❑ Rectal Bleeding	
Night Sweats		Black Tarry Stools	
Shortness of Breath ❑ Exertion ❑ At Night		❑ Constipation ❑ Diarrhea	
❑ Palpitation ❑ Fluttering Heart		❑ Parasites ❑ Worms	
Swelling of ❑ Hands ❑ Feet ❑ Ankles		❑ Any Change in Appetite ❑ Eating Habits	
Vericose Veins		❑ Any Change in Bowel Action ❑ Stools	
Extreme ❑ Tiredness ❑ Weakness		Explain	

HABITS

DO YOU...	YES	DO YOU...	YES
Awaken Rested		Like Your Work (hours per day) ❑ Indoors ❑ Outdoors	
Sleep Well		Watch Television (hours per day)	
Average 8 Hours Sleep (per night)		Read (hours per day)	
Have Regular Bowel Movements		Have a Vacation (weeks per year)	
Sex - Entirely Satisfactory		Recreation: Do you participate in sports or have hobbies which give you relaxation at least 3 hours a week?	
Explain Your Exercise:			

WOMEN ONLY

MENSTRUAL HISTORY	
Age at Onset	Are Your Periods: ❑ Heavy ❑ Medium ❑ Light ❑ Regular
Usual Duration of Period Days	Do You Have ❑ Tension ❑ Depression Before Period
Cycle (start to start) Days	Do You Have ❑ Cramps ❑ Pain with Period
First Day of Last Period	Do You Have Hot Flashes?

TOTAL PREGNANCIES...		
Children Born Alive (how many)	Still Born (how many)	Miscarriages (how many)
Cesarean Sections (how many)	Prematures (how many)	Any Complications?

EMOTIONS

ARE YOU OFTEN...	YES	ARE YOU OFTEN	YES	ARE YOU OFTEN...	YES
Depressed		Jumpy		Jittery	
Anxious		Irritable		Is Concentration Difficult?	

SIGNATURE: ____________________ DATE: __________