

3. HOSPITALIZATIONS:

- List all your prior hospitalizations:

<i>Illness / operation</i>	<i>Where</i>	<i>Year</i>

4. YOUR HEALTH HISTORY:

- Have you had any of the following?

<i>YES</i>	<i>NO</i>	<i>Illness</i>
		Asthma
		Blood transfusion
		Cancer
		Heart disease <i>such as heart murmur, chest pains</i>
		High blood pressure
		HIV test <i>for the AIDS virus</i>
		Liver disease, yellow jaundice, hepatitis
		Mental troubles or nervous breakdown
		Pneumonia
		Rheumatic fever
		Serious injury or accident
		Sugar diabetes
		Thyroid gland trouble
		Tuberculosis (TB)
		Uncontrolled bleeding

5. FAMILY HEALTH HISTORY:

- Please list your family members and their health status:

Family member	Year born	If living, present health			If not living	
		Good	Fair	Poor	Age at death	Cause of death
Mother						
Father						
Brothers/sisters <i>(please list)</i>						
Children <i>(please list)</i>						

- Does anyone in your family have heart disease? YES NO ...diabetes? YES NO ...another hereditary disease? YES NO

- Does anyone in your family have a history of cancer? YES NO. If yes, please list: _____

6. SYMPTOMS:

- Please mark (*with an X*) if you have any of the following symptom now or have had them in the past:

NOW PAST HEAD, EYES, EARS, NOSE, THROAT

- | | | |
|-----------|-----------|-------------------------|
| <u> </u> | <u> </u> | Dizziness |
| <u> </u> | <u> </u> | Severe headaches |
| <u> </u> | <u> </u> | Double vision |
| <u> </u> | <u> </u> | Poor eyesight |
| <u> </u> | <u> </u> | Ear or hearings trouble |
| <u> </u> | <u> </u> | Frequent nose trouble |
| <u> </u> | <u> </u> | Persistent hoarseness |
| <u> </u> | <u> </u> | Teeth trouble |
| <u> </u> | <u> </u> | Sore mouth |

NOW PAST LUNGS

- | | | |
|-----------|-----------|---------------------------|
| <u> </u> | <u> </u> | Cough |
| <u> </u> | <u> </u> | Persistent wheezing |
| <u> </u> | <u> </u> | Shortness of breath |
| <u> </u> | <u> </u> | Chest pain when breathing |

NOW PAST HEART and CIRCULATION

- | | | |
|-----------|-----------|-------------------------|
| <u> </u> | <u> </u> | Chest pain when walking |
| <u> </u> | <u> </u> | Heart palpitation |
| <u> </u> | <u> </u> | Leg vein trouble – |
| <u> </u> | <u> </u> | Leg pain when walking |
| <u> </u> | <u> </u> | Ankle swelling |

NOW PAST STOMACH and GASTROINTESTINAL

- | | | |
|-----------|-----------|---------------------------------|
| <u> </u> | <u> </u> | Trouble swallowing |
| <u> </u> | <u> </u> | Frequent or severe nausea |
| <u> </u> | <u> </u> | Frequent or severe heartburn |
| <u> </u> | <u> </u> | Frequent indigestion |
| <u> </u> | <u> </u> | Frequent or severe stomach pain |
| <u> </u> | <u> </u> | Frequent or severe vomiting |
| <u> </u> | <u> </u> | Vomiting blood |
| <u> </u> | <u> </u> | Yellow jaundice |
| <u> </u> | <u> </u> | Prolonged or frequent diarrhea |
| <u> </u> | <u> </u> | Constipation |
| <u> </u> | <u> </u> | Blood or black bowel movements |
| <u> </u> | <u> </u> | Hemorrhoids (piles) |

NOW PAST BONES, JOINTS, MUSCLES

- | | | |
|-----------|-----------|--------------------------|
| <u> </u> | <u> </u> | Joint pains and swelling |
| <u> </u> | <u> </u> | Severe lack of strength |

NOW PAST URINARY

- | | | |
|-----------|-----------|-----------------------------------|
| <u> </u> | <u> </u> | Frequent urination |
| <u> </u> | <u> </u> | Painful urination |
| <u> </u> | <u> </u> | Bloody urine |
| <u> </u> | <u> </u> | Trouble starting urine |
| <u> </u> | <u> </u> | Urinate more than 2 times a night |

NOW PAST NERVOUS SYSTEM

- | | | |
|-----------|-----------|--|
| <u> </u> | <u> </u> | Lack of energy |
| <u> </u> | <u> </u> | Frequent loss of balance |
| <u> </u> | <u> </u> | Fainting spells (black outs) |
| <u> </u> | <u> </u> | Convulsions (seizures, fits, epilepsy) |
| <u> </u> | <u> </u> | Tremor (shaking, trembling) |
| <u> </u> | <u> </u> | Paralysis |
| <u> </u> | <u> </u> | Numbness (body parts "go to sleep") |
| <u> </u> | <u> </u> | Nervousness |
| <u> </u> | <u> </u> | Trouble sleeping |
| <u> </u> | <u> </u> | Memory trouble |
| <u> </u> | <u> </u> | Depression (feeling blue) |

NOW PAST REPRODUCTION, MALE

- | | | |
|-----------|-----------|-----------------|
| <u> </u> | <u> </u> | Testicular Pain |
|-----------|-----------|-----------------|

NOW PAST REPRODUCTION, FEMALES

- | | | |
|-----------|-----------|---------------------------------------|
| <u> </u> | <u> </u> | Breast lumps or discharge |
| <u> </u> | <u> </u> | Unusual vaginal bleeding or discharge |
| <u> </u> | <u> </u> | When was your last pap smear? |

NOW PAST GENERAL

- | | | |
|-----------|-----------|---------------------------------|
| <u> </u> | <u> </u> | Unexplained weight loss or gain |
| <u> </u> | <u> </u> | Unexplained fever |
| <u> </u> | <u> </u> | Night sweats |

NOW PAST SKIN

- | | | |
|-----------|-----------|---------------------------------|
| <u> </u> | <u> </u> | Persistent skin rash or itching |
|-----------|-----------|---------------------------------|

7. SOCIAL HISTORY:

Occupation: _____

Job's physical requirements: _____

8. HABITS:

- Smoking (*please circle*) cigarettes pipe cigar none # years: _____ Daily amount: _____
- Alcohol (*please circle*) beer wine other liquors none Amount per week: _____
- Hours of sleep per night: _____
- Meals per day: _____

* * *

I GIVE THE PHYSICIANS AND OFFICE STAFF PERMISSION TO DISCUSS MY MEDICAL CONDITION (PLEASE LIST FAMILY MEMBERS AND FRIENDS ONLY),

WITH _____

WHO IS (relationship) _____ AT PHONE # _____

AND/OR _____

WHO IS (relationship) _____ AT PHONE # _____

AND/OR _____

WHO IS (relationship) _____ AT PHONE # _____

* * *

I GIVE THE OFFICE STAFF PERMISSION TO DISCUSS MY FINANCIAL SITUATION:

WITH _____

WHO IS (RELATIONSHIP) _____ AT PHONE # _____

WITH _____

WHO IS (RELATIONSHIP) _____ AT PHONE # _____

* * *

THIS RELEASE CAN BE CHANGED AT ANY TIME BY YOURSELF UPON REQUEST

Signature: _____ Date _____