Why are you here to see the doctor? __________________________________________________
________________________________________________________________________________

Please CIRCLE those symptoms that you frequently experience.

**CENTRAL NERVOUS SYSTEM:**
- Headaches
- Dizziness
- Seizures
- Unconsciousness
- Paralysis
- Speech problems
- Fainting
- Poor memory

**EYES:**
- Blindness
- Glaucoma
- Cataracts
- Double vision

**EARS:**
- Itching
- Draining
- Ringing
- Hearing loss

**NOSE:**
- Sneezing
- Runny nose
- Nosebleeds
- Trouble breathing

**MOUTH-THROAT:**
- Sore throat
- Hoarseness
- Bad breath
- Excessive phlegm

**RESPIRATORY:**
- Wheezing
- Cough
- Sinus
- Shortness of breath

**CARDIOVASCULAR:**
- Chest pain
- Rapid pulse
- Irregular pulse

**GASTROINTESTINAL:**
- Heartburn
- Nausea
- Vomiting
- Trouble swallowing
- Diarrhea
- Pain
- Bleeding
- Food intolerance

**MUSCLES & JOINTS:**
- Joint pain
- Weakness
- Back trouble
- Deformities

**SKIN:**
- Rash
- Growths
- Eczema
- Psoriasis

**GENITO-URINARY:**
- Vaginal infections
- Frequent urination

**MISCELLANEOUS:**
- Allergic reaction to stinging insects? ________
- Allergies to foods or LATEX? ______________

Please CIRCLE any medical problems that you have had:

- Cancer— of what part of the body ___________________________________________
- Diabetes
- High blood pressure
- Gout
- Thyroid disease
- Arthritis
- Heart trouble
- Angina
- Heart attack
- Mitral valve prolapse
- Arrhythmia
- Lung trouble
- Asthma
- Emphysema
- TB
- Pneumonia
- Glaucoma
- Ulcer
- Colitis
- Liver Disease
- Bleeding disorder
- Leukemia
- Seizure disorder
- Stroke
- Back trouble
- Blindness
- High cholesterol
- Nervous disorder
- Urinary tract infection
- Kidney disease
- Prostate trouble
- HIV/AIDS
Please list any **surgeries** you have had and their dates, if known.

________________________________________________________________________________
________________________________________________________________________________

Have you ever had difficulty with **anesthesia**? _____ Yes _____ No

What have you been **hospitalized** for besides surgery?

________________________________________________________________________________
________________________________________________________________________________

Do you **smoke**? ___ Yes ___ No
If yes: _____ Packs per day _____ Years

**Did** you smoke? ___ Yes ___ No
Stopped_____ years ago Smoked_____ packs/day _____ Years

Do you **drink**? ___ Yes ___ No
What & How much? ________________________

**CIRCLE** if you have used: Pipe Cigars Chew Used from ______ to ______ (dates used)

Has anyone in your family been treated for any of the following?

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>RELATIONSHIP (mother, father, sister or brother)</th>
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<tbody>
<tr>
<td>Diabetes</td>
<td>M F S B</td>
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<td>Tuberculosis</td>
<td>M F S B</td>
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<tr>
<td>Hay fever</td>
<td>M F S B</td>
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<tr>
<td>Asthma</td>
<td>M F S B</td>
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<tr>
<td>Heart disease</td>
<td>M F S B</td>
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<tr>
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<tr>
<td>Hearing loss</td>
<td>M F S B</td>
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<tr>
<td>Other (please specify)</td>
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What drugs are you **allergic** to?

________________________________________________________________________________
________________________________________________________________________________

Please list **medications** you take— including aspirin and eye or ear drops.

<table>
<thead>
<tr>
<th>MEDICATION NAME</th>
<th>STRENGTH (MG)</th>
<th>TIMES PER DAY</th>
<th>MEDICATION NAME</th>
<th>STRENGTH (MG)</th>
<th>TIMES PER DAY</th>
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</table>

Are you allergic to **LATEX**? _____ Yes _____ No

Women only: Is it possible that you are **pregnant** now? _____ Yes _____ No

**Anything else** you feel is important:______________________________

________________________________________________________________________________