



Allergies to medications	
Name the Drug	Reaction You Had

### HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.			
<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)		<input type="checkbox"/> moderate exercise
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		<input type="checkbox"/> regular exercise
	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>			
		<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
<b>Drugs</b>	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F				

<b>Name</b> <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
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<b>WOMEN ONLY</b>
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Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

<b>MEN ONLY</b>
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Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<b>OTHER PROBLEMS</b>
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Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.
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<input type="checkbox"/> Neurology: Headaches, Dizziness, Confusion	<input type="checkbox"/> Gastroenterology: Acid Reflex, Bloating, Abd. Pain, Abd. Swelling	<b>Recent changes in:</b> (Please Explain)
<input type="checkbox"/> Muscle: Cramps, Stiffness, Swelling	<input type="checkbox"/> Respiratory: Dry mouth, sputum, Persistent cough	<input type="checkbox"/> <i>Appetite:</i>
<input type="checkbox"/> Skin rash, mole, Lumps	<input type="checkbox"/> Chest/Heart: pain, palpitation	<input type="checkbox"/> <i>Weight:</i>
<input type="checkbox"/> Head/Neck pain ,swelling,	<input type="checkbox"/> Back/joint pain, stiffness, Swelling	<input type="checkbox"/> <i>Energy level:</i>
<input type="checkbox"/> Ears pain, discharge, ringing	<input type="checkbox"/> Intestinal constipation, diarrhea, Change in stool	<input type="checkbox"/> <i>Ability to sleep:</i>
<input type="checkbox"/> Nose: congestion, Bleeding, Loss of Smell	<input type="checkbox"/> Urinary Frequent, Uncontrolled, Burning Sensation	<input type="checkbox"/> <i>Physiological:</i>
<input type="checkbox"/> Throat: pain, swelling, Discharge	<input type="checkbox"/> Brain: Weakness, Numbness, Memory Loss	<input type="checkbox"/> <i>Other pain/discomfort:</i>
<input type="checkbox"/> Lungs: difficulty breathing, wheezing	<input type="checkbox"/> Circulation Leg pain, Numb limbs, Varicose veins	