PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR HEALTH:

Constitutional
- Good general health ____ No Yes
- Recent weight change ____ No Yes
- Fever ____ No Yes
- Fatigue ____ No Yes
- Headaches ____ No Yes

Eyes
- Eye disease or injury ____ No Yes
- Wear glasses/contacts ____ No Yes
- Blurred/double vision ____ No Yes
- Glaucoma ____ No Yes
- Eye surgery ____ No Yes

Ear/Nose/Mouth/Throat
- Hearing loss/ringing ____ No Yes
- Earaches or drainage ____ No Yes
- Chronic sinus problems ____ No Yes
- Nose bleeds ____ No Yes
- Sore throat/voice change ____ No Yes
- Swollen glands in neck ____ No Yes

Cardiovascular
- Heart trouble ____ No Yes
- Chest pain ____ No Yes
- Palpitations ____ No Yes
- Shortness of breath ____ No Yes
- Swelling of feet/ankles/hands ____ No Yes

Respiratory
- Chronic/frequent coughs ____ No Yes
- Spitting up blood ____ No Yes
- Asthma or wheezing ____ No Yes

Gastrointestinal
- Loss of appetite ____ No Yes
- Change in bowel movement ____ No Yes
- Nausea/vomiting ____ No Yes
- Frequent diarrhea ____ No Yes
- Constipation ____ No Yes
- Rectal bleeding/blood in stool ____ No Yes
- Abdominal pain/heart burn ____ No Yes
- Peptic ulcer ____ No Yes

Genitourinary
- Frequent urination ____ No Yes
- Blood in urine ____ No Yes
- Kidney stones ____ No Yes
- Sexual difficulties ____ No Yes
- Male testicle pain ____ No Yes
- Use of Flomax ____ No Yes

Musculoskeletal
- Joint pain ____ No Yes
- Joint stiffness or swelling ____ No Yes
- Muscle pain/cramps ____ No Yes
- Back pain ____ No Yes
- Cold extremities ____ No Yes
- Difficulty in walking ____ No Yes

Integumentary (skin, breast)
- Rash or itching ____ No Yes
- Change in skin color ____ No Yes
- Varicose veins ____ No Yes
- Breast pain or lump ____ No Yes
- Breast discharge ____ No Yes

Neurological
- Frequent/recent headaches ____ No Yes
- Light-headed/dizzy ____ No Yes
- Convulsions/seizures ____ No Yes
- Numbness/tingling ____ No Yes
- Tremors ____ No Yes
- Stroke/paralysis ____ No Yes
- Head injury ____ No Yes

Psychiatric
- Memory loss/confusion ____ No Yes
- Nervousness ____ No Yes
- Depression ____ No Yes
- Insomnia ____ No Yes

Endocrine
- Gland/hormone ____ No Yes
- Thyroid disease ____ No Yes
- Diabetes ____ No Yes
- Excessive thirst/urination ____ No Yes
- Heat/cold intolerance ____ No Yes

Hematologic/Lymphatic
- Slow to heal cuts ____ No Yes
- Bleeding/bruising tendency ____ No Yes
- Anemia ____ No Yes
- Phlebitis ____ No Yes
- Past transfusion ____ No Yes
- Enlarged glands ____ No Yes

Allergic/Immunologic

History of skin or other reactions to:
- Penicillin/antibiotic ____ No Yes
- Novocaine or other anesthetics ____ No Yes
- Tetanus antitoxin or other serum ____ No Yes
- Iodine, methiolate or other ____ No Yes

Other drugs: _____

_____

Known food allergies _____

_____

FULL NAME (PLEASE PRINT):

_____

DATE OF BIRTH:

_____

Month Day Year

PLEASE SIGN:

_____

DATE:

_____