

NAME _____ date of birth _____ age _____ date _____

In order for us to provide you with effective medical care, we need to update some basic information about your past and present health. We also need to ask about your lifestyle because it affects your physical and emotional well being. The questions on the next pages cover the topics we will discuss. Please answer them as best you can. Mark an X on the line following the word "No" or "Yes" when either describes your symptoms or history. Use a question mark when you don't understand a question or aren't sure of your answer. Thank you for completing this form

Before you start, please list all questions you have for the doctor: _____

Since your last visit have you had urgent care
or a change in health? _____ no _____ yes _____
If yes, what was it? _____

Has there been a change in the health of your mother,
father, sisters, spouse, or children? _____ no _____ yes _____
What was the change? _____

Please list all the medicines, tonics, and over-the-counter medicines, vitamins and supplements you take:
Name _____ strength _____ how often _____ for what _____

please bring all your bottles of medication to each appointment

During the past year, have you:

- 1. had frequent headaches? _____ no _____ yes _____
- 2. felt dizzy, fainted or had blackouts? _____ no _____ yes _____
- 3. had seizures or convulsions? _____ no _____ yes _____
- 4. noticed any lumps on your body or
swollen glands _____ no _____ yes _____
- 5. had eye trouble? _____ no _____ yes _____
- 6. had difficulty hearing? _____ no _____ yes _____
- 7. had troubles with your ears? _____ no _____ yes _____
- 8. had dental or other mouth problems? _____ no _____ yes _____
- 9. suffered from nose bleeds? _____ no _____ yes _____
- 10. suffered from allergies or hay fever? _____ no _____ yes _____
- 11. noticed any hoarseness in your voice? _____ no _____ yes _____

During the past year, have you:

- 12. been wheezing or been short of breath? _____ no _____ yes _____
- 13. had strange, persistent odors or tastes? _____ no _____ yes _____
- 14. frequently been coughing? _____ no _____ yes _____
- 15. sweated more than usual or had "night sweats"? _____ no _____ yes _____
- 16. had a racing heart or palpitations? _____ no _____ yes _____
- 17. had tightness or pains in your chest? _____ no _____ yes _____
- 18. had swollen feet or ankles? _____ no _____ yes _____

36. If you are past menopause, have you
had vaginal bleeding? _____ no _____ yes _____

- If you are past your menopause, please skip to question 39
- 37. Has there been any change in your periods? _____ no _____ yes _____
 - 38. Have you noticed bleeding between your periods? _____ no _____ yes _____
 - 39. Do you have discomfort during intercourse? _____ no _____ yes _____
 - 40. Do you bleed from your vagina after intercourse? _____ no _____ yes _____

During the past year, have you had:

- 19. heartburn or indigestion? _____ no _____ yes _____
- 20. abdominal discomfort or pain? _____ no _____ yes _____
- 21. bouts of nausea or vomiting? _____ no _____ yes _____
- 22. difficulty swallowing? _____ no _____ yes _____
- 23. pains in your rectum? _____ no _____ yes _____
- 24. bowel movements that were bloody or tarry? _____ no _____ yes _____
- 25. any change in your bowel habits? _____ no _____ yes _____
- 26. If you are over 50, have you ever had sigmoidoscopy? _____ no _____ yes _____
If yes, when? _____
- 27. frequent urination during the day or at night? _____ no _____ yes _____
- 28. uncomfortable or difficult urination? _____ no _____ yes _____

For Men Only: During the past year, have you:

- 29. had a drip or discharge from your penis? _____ no _____ yes _____
- 30. noticed lumps or swellings on your testicles? _____ no _____ yes _____
- 31. had difficulty with your erection? _____ no _____ yes _____

For Women Only:

- 32. When was your last menstrual period? _____
- 33. Was it normal? _____ yes _____ no _____
- 34. number of days between periods _____
- 35. Length of bleeding, in days _____
- 71. Have your pets been vaccinated for rabies? _____ yes _____ no _____
- 72. Do you have a Living Will and Health Care Proxy filed with us? _____ yes _____ no _____

Work and Play:

- 73. Are you generally satisfied with your work? _____ yes _____ no _____
- 74. What kinds of exercise do you do? _____
- 75. What are your hobbies or leisure activities? _____

41. Do you have any vaginal itching, burning or discharge? no ___ yes ___
 42. discomfort or pain in your pelvis? no ___ yes ___
 43. problems with your breasts? no ___ yes ___
 44. When was your last Pap test?
 45. Have you ever had an abnormal Pap test? no ___ yes ___
 46. Have you ever had an abnormal mammogram? no ___ yes ___
 47. Date of last mammogram:

For Both Men and Women, During the past year have you:

48. had any skin problems or noticed any changes
 in your skin or glands? no ___ yes ___
 49. Do you use sunscreen routinely? yes ___ no ___
 50. had aching muscles or joints? no ___ yes ___
 51. had leg cramps? no ___ yes ___

During the past year, have you:

52. felt exhausted or fatigued most of the time? no ___ yes ___
 53. felt "blue", lonely or depressed? no ___ yes ___
 54. been more irritable than usual? no ___ yes ___
 55. had frequent crying spells or felt like crying? no ___ yes ___
 56. had difficulty trying to calm down or relax? no ___ yes ___
 57. been overly anxious or been worrying a lot? no ___ yes ___
 58. felt that you or others would be better off
 if you were dead? no ___ yes ___
 59. desired or sought counseling? no ___ yes ___

Eating, Drinking, and Environmental:

60. Do you use salt at the table? no ___ yes ___
 61. Has your appetite noticeably changed in the past month? no ___ yes ___
 62. Have you gained/lost 10 or more pounds
 in the past 6 months? no ___ yes ___
 63. Do you drink caffeinated coffee, tea or soda?
 How much? no ___ yes ___
 64. Do you smoke or use tobacco now? no ___ yes ___
 65. If you stopped some time ago, when was it? no ___ yes ___
 66. Do you drink more than 2 alcoholic bevarages a day? no ___ yes ___
 67. Have you ever felt you ought to cut down on your drinking?
 -ever been annoyed by people criticizing your drinking? no ___ yes ___
 -ever felt bad or guilty about your drinking? no ___ yes ___
 -ever had a moring "eye opener" to steady your nerves? no ___ yes ___
 68. Are you or have you used prescription drugs
 without having a prescription? no ___ yes ___
 - ever used other "recreational" drugs? no ___ yes ___
 69. What is the age of your home?
 70. Has your home been tested for radon? no ___ yes ___

76. In what kinds of groups, organization,
 or community activities do you participate?
 77. List the countries that you have visited
 in the past 6 months
 78. Do you usually wear safety belts when riding in a car? yes ___ no ___
 79. Are there any guns in your house?
 What type? no ___ yes ___
 Are they locked up? yes ___ no ___
 80. Are there smoke detectors in your house? yes ___ no ___

Sexuality:

81. Are you sexually active now? yes ___ no ___
 82. Are you generally satisfied with sex? yes ___ no ___
 83. What do you do for family planning
 or birth control?
 84. Do you have sexual concerns? no ___ yes ___
 85. In the last 5 years how many sexual partners
 have you had?
 86. Would you like an HIV test? no ___ yes ___
 87. Do you use or have contact with anyone
 who uses IV drugs? no ___ yes ___

Family Appgar Assessment

"Family" here refers to the relatives or close friends with whom
 you usually live or look to for continuing emotional support.

Are you satisfied with the way your family:

88. - helps you when you are in trouble? yes ___ no ___
 89. - discusses things and shares your problems? yes ___ no ___
 90. - accepts your new interests or changes in your lifestyle? yes ___ no ___
 91. - espreses affection and responds to your feelings or moods? yes ___ no ___
 92. - spends time together with you? yes ___ no ___
 93. Are you concerned about physical violence or possible
 incest in your family? no ___ yes ___

Social Support

94. Is your time well balanced between your work, family,
 and leisure activities? yes ___ no ___
 95. Is your relationship with your friends as good as
 it was last year? yes ___ no ___
 96. Is your relationship with your spouse/partner
 as good as it was last year? yes ___ no ___
 97. Is there someone with whom you can always discuss
 your personal problems? yes ___ no ___
 98. Would you like patient education on any topics?
 What topics? no ___ yes ___
 99. Do you ever feel unsafe at home? yes ___ no ___
 100. Has anyone at home hit or tried to injure you in
 any way? yes ___ no ___