## COMPLETE PHYSICAL EXAM VISIT - HEALTH HISTORY QUESTIONNAIRE

ADDRESS: TELEPHONE; HOME:  MOBILE: WORK:  EMAIL ADDRESS: (To receive health and practice information)  PAST MEDICAL HISTORY: HAVE YOU: NO / YES  Any serious illnesses? N Y Please list Ever been hospitalized? N Y Please list  Ever been hospitalized? N Y Please list  Cancer NO YES Poeumonia NO YE	NAME:			AGE: _	DATE OF BIRT	TH:	TODAY'S DATE:	
EMAIL ADDRESS: (To receive health and practice information)  PAST MEDICAL HISTORY: HAVE YOU: NO / YES IF YES PLEASE LIST  Any serious illnesses? N Y Please list.  Ever been hospitulized? N Y For What? Had any surgeries? NO YES Heart Disease NO YES Pheumonia NO YES Stroke NO YES Diabetes NO YES Chicken Pox NO YES Hepatitis NO YES High Blood Pressure NO YES High Cholesterol NO YES High Cholesterol NO YES Scaudily transmitted NO YES High Cholesterol NO YES Blood Clots NO YES Does a partner, or anyone NO YES at home, hurt, hit or threaten you  MEDICATION: (INCLUDE HERBS AND VITIMINS)  HOW OFTEN TAKEN:  ALLERGIES: Do you have any drug allergies? NO YES If yes, to what?  AGE AT DEATH — CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)  BROTHER(S)	ADDRESS:							
(To receive health and practice information)  PAST MEDICAL HISTORY: HAVE YOU: NO / YES IF YES PLEASE LIST  Any serious illnesses? N Y Please list Ever been hospitalized? N Y Por What? Had any surgeries? N Y Please list  Cancer NO YES Stroke NO YES Pneumonia NO YES Diabetes NO YES Tibebreulosis NO YES Diabetes NO YES Hepatitis NO YES High Cholesterol NO YES High Cholesterol NO YES Blood Clots NO YES Sexually transmitted NO YES Blood Clots NO YES Does a partner, or anyone NO YES diseases  MEDICATION: (INCLUDE HERBS AND VITIMINS)  HOW OFTEN TAKEN:  ALLERGIES: Do you have any drug allergies? NO YES If yes, to what?  AGE-HEALTH STATUS AGE AT DEATH — CAUSE OF DEATH FATHER:  MOTHER: BROTHER(S)	TELEPHONE; HOME:			MC	OBILE:		WORK:	
PAST MEDICAL HISTORY: HAVE YOU: NO / YES IF YES PLEASE LIST  Any serious illnesses? N Y Please list Ever been hospitalized? N Y For What? Had any surgeries? N Y Please list  Cancer NO YES Heart Disease NO YES Preumonia NO YES Stroke NO YES Diabetes NO YES Diabetes NO YES Hepatitis NO YES High Blood Pressure NO YES High Cholesterol NO YES Sexually transmitted NO YES Blood Clors NO YES Does a partner, or anyone NO YES at home, hurt, hit or threaten you  MEDICATION: (INCLUDE HERBS AND VITIMINS)  HOW OFTEN TAKEN:  ALLERGIES: Do you have any drug allergies? NO YES If yes, to what?  FAMILY HISTORY: (IF LIVING) AGE-HEALTH STATUS  AGE AT DEATH—CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)  BROTHER(S)								
HAVE YOU:  NO / YES  IF YES PLEASE LIST  Any serious illnesses?  N Y  Please list  Ever been hospitalized?  N Y  For What?  Cancer  NO  YES  Heart Disease  NO  YES  Pheumonia  NO  YES  Stroke  NO  YES  Tuberculosis  NO  YES  Diabetes  NO  YES  High Cholesterol  NO  YES  Aller Gieses  Does a partner, or anyone NO  YES  at home, hurt, hit or threaten you  MEDICATION: (INCLUDE HERBS AND VITIMINS)  HOW OFTEN TAKEN:   ALLER GIES:  Do you have any drug allergies?  NO  YES  If yes, to what?  LIF DECEASED)  AGE-HEALTH STATUS  AGE AT DEATH — CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)	(To receive health and pr	ractice in	itormation	1)				
Any serious illnesses?	PAST MEDICAL HIST	ORY:						
Ever been hospitalized? N Y Please list	HAVE YOU:		N	O / YES	IF YES PLE	EASE LIST		
Cancer NO YES Heart Disease NO YES Pneumonia NO YES Stroke NO YES Tuberculosis NO YES Diabetes NO YES Chicken Pox NO YES Hepatitis NO YES High Blood Pressure NO YES High Cholesterol NO YES Sexually transmitted NO YES Blood Clots NO YES diseases Does a partner, or anyone NO YES at home, hurt, hit or threaten you  MEDICATION: (INCLUDE HERBS AND VITIMINS)  ALLERGIES: Do you have any drug allergies? NO YES If yes, to what?  What symptoms did you have?  FAMILY HISTORY: (IF LIVING)  AGE-HEALTH STATUS  AGE AT DEATH — CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)					Please list			
Cancer NO YES Heart Disease NO YES Pneumonia NO YES Stroke NO YES Tuberculosis NO YES Diabetes NO YES Chicken Pox NO YES Hepatitis NO YES High Blood Pressure NO YES High Cholesterol NO YES Sexually transmitted NO YES Blood Clots NO YES diseases Does a partner, or anyone NO YES at home, hurt, hit or threaten you  MEDICATION: (INCLUDE HERBS AND VITIMINS)  ALLERGIES: Do you have any drug allergies? NO YES If yes, to what?  What symptoms did you have?  FAMILY HISTORY: (IF LIVING)  AGE-HEALTH STATUS  AGE AT DEATH — CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)					For What?			
Pneumonia NO YES Stroke NO YES Tuberculosis NO YES Diabetes NO YES Chicken Pox NO YES Hepatitis NO YES High Blood Pressure NO YES High Cholesterol NO YES Sexually transmitted NO YES Blood Clots NO YES diseases Does a partner, or anyone NO YES at home, hurt, hit or threaten you  MEDICATION: (INCLUDE HERBS AND VITIMINS)  HOW OFTEN TAKEN:  ALLERGIES: Do you have any drug allergies? NO YES If yes, to what?  What symptoms did you have?  FAMILY HISTORY: (IF LIVING)  AGE-HEALTH STATUS  AGE AT DEATH—CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)  BROTHER(S)	Had any surgeries?			NY	Please list			
Tuberculosis NO YES Diabetes NO YES Chicken Pox NO YES Hepatitis NO YES High Blood Pressure NO YES High Cholesterol NO YES Sexually transmitted NO YES Blood Clots NO YES Sexually transmitted NO YES Blood Clots NO YES diseases Does a partner, or anyone NO YES at home, hurt, hit or threaten you  MEDICATION: (INCLUDE HERBS AND VITIMINS)  HOW OFTEN TAKEN:  ALLERGIES: Do you have any drug allergies? NO YES If yes, to what?  FAMILY HISTORY: (IF LIVING)  AGE-HEALTH STATUS  AGE AT DEATH — CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)  BROTHER(S)	Cancer	NO	YES		Heart Disease	NO	YES	
Chicken Pox NO YES Hepatitis NO YES High Blood Pressure NO YES High Cholesterol NO YES Sexually transmitted NO YES diseases  Does a partner, or anyone NO YES at home, hurt, hit or threaten you  MEDICATION: (INCLUDE HERBS AND VITIMINS)  HOW OFTEN TAKEN:  ALLERGIES: Do you have any drug allergies? NO YES If yes, to what?  FAMILY HISTORY: (IF LIVING)  AGE-HEALTH STATUS  AGE AT DEATH — CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)  BROTHER(S)	Pneumonia	NO	YES		Stroke	NO	YES	
High Blood Pressure NO YES Sexually transmitted NO YES Blood Clots NO YES diseases  Does a partner, or anyone NO YES at home, hurt, hit or threaten you  MEDICATION: (INCLUDE HERBS AND VITIMINS)  HOW OFTEN TAKEN:  ALLERGIES: Do you have any drug allergies? NO YES If yes, to what?  FAMILY HISTORY: (IF LIVING)  AGE-HEALTH STATUS  AGE AT DEATH — CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)  BROTHER(S)	Tuberculosis	NO						
High Blood Pressure NO YES Sexually transmitted NO YES Blood Clots NO YES Does a partner, or anyone NO YES at home, hurt, hit or threaten you  MEDICATION: (INCLUDE HERBS AND VITIMINS)  HOW OFTEN TAKEN:  ALLERGIES: Do you have any drug allergies? NO YES If yes, to what?  What symptoms did you have?  FAMILY HISTORY: (IF LIVING)  AGE-HEALTH STATUS  AGE AT DEATH — CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)  BROTHER(S)	Chicken Pox	NO	YES			NO	YES	
Sexually transmitted NO YES  diseases  Does a partner, or anyone NO YES  at home, hurt, hit or threaten you  MEDICATION: (INCLUDE HERBS AND VITIMINS)  HOW OFTEN TAKEN:  ALLERGIES:  Do you have any drug allergies? NO YES If yes, to what?  What symptoms did you have?  FAMILY HISTORY: (IF LIVING)  AGE-HEALTH STATUS  AGE AT DEATH — CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)		NO	YES		High Cholesterol	NO	YES	
at home, hurt, hit or threaten you  MEDICATION: (INCLUDE HERBS AND VITIMINS)  HOW OFTEN TAKEN:  ALLERGIES: Do you have any drug allergies? NO YES If yes, to what?  What symptoms did you have?  FAMILY HISTORY: (IF LIVING)  AGE-HEALTH STATUS  AGE AT DEATH - CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)	Sexually transmitted	NO	YES		Blood Clots	NO	YES	
MEDICATION: (INCLUDE HERBS AND VITIMINS)  HOW OFTEN TAKEN:  ALLERGIES: Do you have any drug allergies? NO YES If yes, to what?  What symptoms did you have?  FAMILY HISTORY: (IF LIVING)  AGE-HEALTH STATUS  AGE AT DEATH - CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)	diseases						YES	
ALLERGIES: Do you have any drug allergies? NO YES If yes, to what?  What symptoms did you have?  FAMILY HISTORY: (IF LIVING)  AGE-HEALTH STATUS  AGE AT DEATH - CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)  BROTHER(S)					at nome, nart, mt or t	incuten you		
Do you have any drug allergies? NO YES If yes, to what?	MEDICATION: (INCL	UDE HE	RBS ANI	O VITIMINS)		HOW	<u>OFTEN TAKEN:</u>	
What symptoms did you have?  FAMILY HISTORY: (IF LIVING)  AGE-HEALTH STATUS  AGE AT DEATH – CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)		lergies?	NO	YES If ve	es, to what?			
AGE-HEALTH STATUS  AGE AT DEATH - CAUSE OF DEATH  FATHER:  MOTHER:  BROTHER(S)		C		•				
FATHER:  MOTHER:  BROTHER(S)	FAMILY HISTORY: (I	F LIVIN	<u>[G)</u>			(IF DE	CEASED)	
FATHER:  MOTHER:  BROTHER(S)	AGE-I	I STATUS	S	AC	AGE AT DEATH – CAUSE OF DEATH			
MOTHER:				_				
BROTHER(S)	MOTHER:							
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HAS ANY BLOOD RELATIVES HAD? WHICH RELATIVE? HAS ANY BLOOD RELATIVES HAD? WHICH RELATIVE? NO \_\_\_\_\_ Gout or Arthritis NO Cancer YES YES \_\_\_\_\_ Glaucoma Diabetes NO NO YES YES YES NO **Heart Disease** NO Asthma or Hives YES Stroke NO YES High blood pressure NO YES **Bleeding Problems** NO YES **IMMUNIZATIONS:** Have you had the basic immunization series of: Tetanus and Diphtheria NO YES Measles, Mumps and Rubella (MMR) NO YES Polio NO YES Pneumonia Vaccine NO YES Hepatitis A NO YES When was your last tetanus shot? \_\_\_\_ Hepatitis B NO YES Gardasil NO YES Zostovax NO YES Meningococal NO YES SOCIAL HISTORY ARE YOU: Married Divorced Separated Widowed (PLEASE CIRCLE) Single Are you living with our husband, wife, or partner? YES NO Is your sex life satisfactory? YES NO Do you have dependents at home YES NO Do you drink alcoholic beverages? NO YES How much per day/week? \_\_\_\_\_ Has anyone told you that you drink too much? NO YES How many? \_\_\_\_\_ How Long? \_\_\_\_\_ Do you now smoke? NO YES Do you drink coffee, cola or tea? How many cups? NO YES Do you exercise? NO YES How many times per week? \_\_\_\_\_ Which drugs and when? Have you used illicit drugs? YES NO Have you ever been tested for HIV? YES Would you like to be? \_\_\_\_\_ What is / was your occupation? Highest education obtained: Describe job stress: (High) (Medium) (Low) Describe: YES Do you wear seat belts? NO SCREENING TESTS: (IF APPLICABLE) Have you ever had a: Mammogram? NO YES When was it last done? When was it last done? Bone Density Test? NO YES Chest X-Ray? When was it last done? YES NO EKG? NO YES When was it last done? When was it last done? Exercise Stress Test? NO YES Colonoscopy? NO YES When was it last done? SYSTEMS REVIEW: Do you have any of the following: **GENERAL:** NECK: Unexplained weight loss? NO YES Stiffness? NO YES Neck injury? Chronic fevers? NO YES NO YES Loss of appetite? YES Enlarged neck glands? NO NO YES SKIN: RESPIRATORY: Skin disease? Coughing / Spitting blood? NO YES NO YES Chronic cough? Jaundice YES YES NO NO Asthma or wheezing? Hives or Eczema? NO YES NO YES Shortness of breath? Frequent infections or boils? NO YES NO YES Abnormal moles? NO YES Difficulty walking 2 blocks? NO Yes Night sweats? NO YES

Skin tested for tuberculosis?

CARDIOVASCULAR:

Chest pain or angina?

NO

NO

YES

YES

**HEAD-EYES-EARS-NOSE-THROAT** 

YES

YES

YES

NO

NO

NO

Eye disease?

Blurred vision?

Do you wear glasses?

Frequent headaches	Glaucoma?	NO	YES	Heart trouble?	NO	YES
Ichip yeys, runny nose, sneezing? NO YES   Shortness of breath? NO YES   Chronic ringing in ear? NO YES   When laying down? NO YES   Sinus trouble? NO YES   Wake up short of breath? NO YES   Hearing loss or disease? NO YES   Rapid or skipped heartheass? NO YES   Dizziness or fainting spells? NO YES   Rapid or skipped heartheass? NO YES   Swelling of hands, feet or ankles? NO YES   Paint in calves or buttles? NO YES   Paint in calves or buttles? NO YES   Swelling of hands, feet or ankles? NO YES   Sw						
Frequent noseblecks? NO YES Chronic ringing in ear? NO YES Sinus trouble? NO YES Heart murmurs? NO YES Heart murmurs? NO YES Heart murmurs? NO YES Dizziness or fainting spells? NO YES Swelling of hands, feet or ankles? NO YES Dizziness or fainting spells? NO YES Swelling of hands, feet or ankles? NO YES Difficulty walking? NO YES Difficulty walking? NO YES Difficulty walking? NO YES Difficulty valking? NO YES NEUROLOGICAL: Statistic or the feet of walking NO YES NEUROLOGICAL: Statistic or greasy food? NO YES NEUROLOGICAL: Statistic or greasy food? NO YES No YES NEUROLOGICAL: Statistic or greasy food? NO YES No						
Chronic ringing in ear?						
Sinus trouble?   NO YES   Heart murmurs?   NO YES						
Hearing loss or disease? NO YES   Sepiling of shands, feet or ankles? NO YES						
Dizziness or fainting spells?   NO   YES						
MUSCULOSKELETAL   Stomach or duodenal ulcer? NO YES   Significant arthritis? NO YES   Signif						
Stomach or duodenal utcer? NO YES   Significant arthritis? NO YES   No YES   Sour taste in throat or mouth? NO YES   Difficulty walking? NO YES   Sour taste in throat or mouth? NO YES   Difficulty walking? NO YES   Sour taste in throat or mouth? NO YES   Difficulty walking? NO YES   Sour taste in throat or mouth? NO YES   Difficulty walking? NO YES   Difficulty walking? NO YES   Coffee or alcohol? NO YES   Pain in calves or buttock on walking NO YES   Coffee or alcohol? NO YES   Weakness in leg or arm? NO YES   Coffee or alcohol? NO YES   Painful varicose veins? NO YES   Coffee or alcohol? NO YES   Stoke? NO YES   Coffee or alcohol? NO YES   Stoke? NO YES   Coffee or alcohol? NO YES   Stoke? NO YES   Cramping, abdominal pain? NO YES   Paralysis? NO YES   Cramping, abdominal pain? NO YES   Paralysis? NO YES   Cramping, abdominal pain? NO YES   Numbness or tingling? NO YES   Cramping, abdominal pain? NO YES   Loss of consciousness? NO YES   Consciousness   NO YES   Cons	Dizzmess of familing spens.	110	125	s weining of hairas, feet of animes.	110	125
Hearburn or indigestion? NO YES Sour taste in throat or mouth? NO YES Use antacids or Tums often? NO YES Use antacids or Tums often? NO YES Pain in calves or buttock on walking NO YES Intolerance to spicy foods NO YES Omiting up blood? NO YES Vomiting up blood? NO YES Sour taste in throat or mouth? NO YES Vomiting up blood? NO YES Vomiting up blood? NO YES Vomiting up blood? NO YES Sour trouble? NO YES Intolerance to greasy food? NO YES Intolerance to great for great g	<b>GASTROINTESTINAL:</b>			<u>MUSCULOSKELETAL</u>		
Heartburn or indigestion? NO YES   Weakness in leg or arm? NO YES	Stomach or duodenal ulcer?	NO	YES	Significant arthritis?	NO	YES
Use antacids or Tums often? NO YES	Heartburn or indigestion?	NO	YES		NO	YES
Intolerance to spicy foods	Sour taste in throat or mouth?	NO	YES	Difficulty walking?	NO	YES
Coffee or alcohol?	Use antacids or Tums often?	NO	YES	Pain in calves or buttock on walking	NO	YES
Vomitting up blood?         NO         YES         Stroke?         NO         YES           Gallbladder trouble?         NO         YES         Stroke?         NO         YES           Intolerance to greasy food?         NO         YES         Seizures?         NO         YES           Liver trouble?         NO         YES         Paralysis?         NO         YES           Cramping, abdominal pain?         NO         YES         No         YES           Chronic constipation?         NO         YES         Loss of consciousness?         NO         YES           Chronic constipation?         NO         YES         Loss of consciousness?         NO         YES           Chronic constipation?         NO         YES         Loss of consciousness?         NO         YES           Frequent diadrarbea?         NO         YES         Loss of consciousness??         NO         YES           Recent change in bowel habits?         NO         YES         Los you sell powell?         NO         YES           Bloody or plack stools?         NO         YES         Are you often depressed?         NO         YES           Hemorrhoids or piles?         NO         YES         Are you usually tired?         NO	Intolerance to spicy foods	NO	YES	Painful varicose veins?	NO	YES
Gallbladder trouble? NO YES   Stroke? NO YES   Intolerance to greasy food? NO YES   Seizures? NO YES   Liver trouble? NO YES   Paralysis? NO YES   Cramping, abdominal pain? NO YES	Coffee or alcohol?	NO	YES			
Intolerance to greasy food?	Vomiting up blood?	NO	YES	NEUROLOGICAL:		
Cramping, abdominal pain? NO YES   Numbness or tingling? NO YES	Gallbladder trouble?	NO	YES	Stroke?	NO	YES
Cramping, abdominal pain? NO YES	Intolerance to greasy food?	NO	YES	Seizures?	NO	YES
Chronic constipation? NO YES Frequent diarrhea? NO YES Uses laxatives often? NO YES Bloody or black stools? NO YES Hemorrhoids or piles? NO YES Are you usually tired? NO YES Hemorrhoids or piles? NO YES Are you often depressed? NO YES Are you often depressed? NO YES Leak urine when cough or sneeze? NO YES Burning or painful ruination? NO YES Burning or painful ruination? NO YES Bloody, pink or brown urine? NO YES Bloody, pink or brown urine? NO YES Bloody, pink or brown urine? NO YES Decrease in strength of urine stream NO YES Discharge from penis? NO YES Difficulty starting/maintaining erections? NO YES Prostate Problems? NO YES Prostate Problems? NO YES Prostate Problems? NO YES NO YES NO YES NO YES Discharge from penis? NO YES Prostate Problems? NO YES Prostate Problems? NO YES Prostate Problems? NO YES NO YES NO YES Discharge from penis? NO YES Prostate Problems? NO	Liver trouble?	NO	YES	Paralysis?	NO	YES
Frequent diarrhea?	Cramping, abdominal pain?	NO	YES	Numbness or tingling?	NO	YES
See laxatives often?	Chronic constipation?	NO	YES	Loss of consciousness?	NO	YES
Recent change in bowel habits? NO YES Bloody or black stools? NO YES Hemorrhoids or piles? NO YES Are you usually tired? NO YES Are you often depressed? NO YES Are you often anxious? NO YES Are you often anxious? NO YES Leak urine when cough or sneeze? NO YES Do you feel hopeless or helpless? NO YES Burning or painful ruination? NO YES Bloody, pink or brown urine? NO YES B	Frequent diarrhea?	NO	YES			
Bloody or black stools? NO YES Hemorrhoids or piles? NO YES Are you often depressed? NO YES  GENITOURINARY Leak urine when cough or sneeze? NO YES Burning or painful ruination? NO YES Burning or painful ruination? NO YES Burning or painful ruination? NO YES Have you over been advised to see Feeling that you must Urinate immediately? NO YES Bloody, pink or brown urine? NO YES Bloody, pink or brown urine? NO YES Decrease in strength of urine stream NO YES Difficulty starting urination? NO YES Difficulty starting urination? NO YES Difficulty starting urination or YES Prostate Problems? NO YES Prostate Problems? NO YES Prostate Problems? NO YES Age when period started years old Frequency of periods: Every days Length of each period NO YES Date of last Pap Smear? Abnormal discharge or odor? NO YES Painful intercourse? NO YES	Uses laxatives often?	NO	YES	EMOTIONAL:		
Are you often depressed? NO YES   Are you often depressed? NO YES   Are you often anaious? NO YES   Are you often anaious? NO YES   Do you feel hopeless or helpless? NO YES   Do you wish you were dead? NO YES   Do you wish you were dead? NO YES   Do you wish you were dead? NO YES   Burning or painful ruination? NO YES   Do you worry often? NO YES   Burning or painful ruination? NO YES   Do you worry often? NO YES   Have you ever been advised to see   Feeling that you must   The you have interest in friends or fun? NO YES   Have you ever been advised to see   Feeling that you must   The you have interest in friends or fun? NO YES   Have you ever been advised to see   Feeling that you must   The you have interest in friends or fun? NO YES   Have you ever been advised to see   Feeling that you must   The you have interest in friends or fun? NO YES   Have you ever been advised to see   Feeling that you must   The you have interest in friends or fun? NO YES   Have you ever been advised to see   Feeling that you must   The you have interest in friends or fun? NO YES   How you ever been advised to see   Feeling that you must   The you ever been advised to see   The you ever been advised to see   Feeling that you must   The you ever been advised to see   The you down the you ever been advised to see   The your ever been advis	Recent change in bowel habits?	NO	YES	Do you sleep well?	NO	YES
Are you often anxious? NO YES  GENITOURINARY Leak urine when cough or sneeze? NO YES Frequent bladder/kidney infections? NO YES Burning or painful ruination? NO YES Bloody, pink or brown urine? NO	Bloody or black stools?	NO	YES	Are you usually tired?	NO	YES
Do you feel hopeless or helpless? NO YES	Hemorrhoids or piles?	NO	YES	Are you often depressed?	NO	YES
Leak urine when cough or sneeze? NO YES Frequent bladder/kidney infections? NO YES Burning or painful ruination? NO YES Bloody pink or brown urine? NO YES Bloody, pink				Are you often anxious?	NO	YES
Frequent bladder/kidney infections? NO YES Burning or painful ruination? NO YES Nighttime urination? NO YES Have you ever been advised to see Feeling that you must Urinate immediately? NO YES Bloody, pink or brown urine? NO YES Kidney stones? NO YES HEMATOLOGICAL: Kidney stones? NO YES Decrease in strength of urine stream NO YES Difficulty starting urination? NO YES Difficulty starting/maintaining erections? NO YES Difficulty starting/maintaining erections? NO YES Prostate Problems? NO YES FOR WOMEN ONLY: Age when period started years old Frequency of periods: Every days Length of each period NO YES NO YES NO YES NO YES Nomber of deliveries? Date of last Pap Smear? Abnormal discharge or odor? NO YES Painful intercourse? NO YES	<u>GENITOURINARY</u>					
Burning or painful ruination? NO YES Nighttime urination? NO YES Have you ever been advised to see Feeling that you mus Urinate immediately? NO YES Bloody, pink or brown urine? NO YES Kidney stones? NO YES HEMATOLOGICAL: Kidney stones? NO YES Unexplained bruising? NO YES Difficulty starting urination? NO YES Decrease in strength of urine stream NO YES Difficulty starting/maintaining erections? NO YES Prostate Problems? NO YES Prostate Problems? NO YES FOR WOMEN ONLY: Age when period started years old Frequency of periods: Every days Length of each period years old Frequency of periods: Every days Length of each period years old of last Pap Smear? Date of last Pap Smear? Abnormal discharge or odor? NO YES Painful intercourse? NO YES Painful intercourse? NO YES Painful intercourse? NO YES Painful intercourse? NO YES Prostate Problems? NO YES Painful intercourse? NO YES Painful intercourse? NO YES Painful intercourse? NO YES Painful intercourse? NO YES Prostate Problems? NO YES Painful intercourse? NO YES						
Nighttime urination? NO YES Feeling that you must Urinate immediately? NO YES Bloody, pink or brown urine? NO YES Kidney stones? NO YES FOR MEN ONLY: Difficulty starting urination? NO YES Decrease in strength of urine stream NO YES Difficulty starting/maintaining erections? NO YES Prostate Problems? NO YES FOR WOMEN ONLY: Age when period started years old Frequency of periods: Every days Length of each period Abnormal discharge or odor? NO YES NO YES NO YES Painful intercourse? NO YES Painful intercourse? NO YES Painful intercourse? NO YES Painful intercourse? NO YES Place a psychiatrist? NO YES HEMATOLOGICAL: Anemia? NO YES Unexplained bruising? NO YES Excessive bleeding? NO YES Excessive bleeding? NO YES Excessive bleeding? NO YES ENDOCRINE (Hormone): Dhoronal brange? NO YES Thyroid disease? NO YES Intolerance to mildly warm or mildly Temperatures? NO YES Change in texture of hair or skin? NO YES Significant change in shoe size NO YES Painful intercourse? NO YES Painful intercourse? NO YES		s? NO				
Teeling that you must Urinate immediately? NO YES					NO	YES
Urinate immediately? NO YES Bloody, pink or brown urine? NO YES Kidney stones? NO YES Anemia? NO YES Unexplained bruising? NO YES Difficulty starting urination? NO YES Decrease in strength of urine stream NO YES Discharge from penis? NO YES Difficulty starting/maintaining erections? NO YES Prostate Problems? NO YES Age when period started years old Frequency of periods: Every days Length of each period NO YES Number of deliveries? Date of last Pap Smear? Abnormal discharge or odor? NO YES Painful intercourse? NO YES Painful intercourse? NO YES Prostate Problems? NO YES Prostate Problems? NO YES FINANCIAL STANCE OF THE MEMATOLOGICAL: Anemia? NO YES ENDOCRINE (Hormone): ENDOCRINE (Hormone):  ENDOCRINE (Hormone):  Thyroid disease? NO YES Thyroid disease? NO YES Intolerance to mildly warm or mildly Temperatures? NO YES Change in texture of hair or skin? NO YES Crave large amounts of fluids? NO YES Significant change in shoe size NO YES NUMBER OF THE MEMATOLOGICAL: Anemia? NO YES ENDOCRINE (Hormone):  Chornone therapy? NO YES Thyroid disease? NO YES Change in texture of hair or skin? NO YES Crave large amounts of fluids? NO YES Painful intercourse? NO YES Painful intercourse? NO YES Painful intercourse? NO YES		NO	YES	•		
Bloody, pink or brown urine? NO YES Kidney stones? NO YES Unexplained bruising? NO YES Excessive bleeding? NO YES Decrease in strength of urine stream NO YES Discharge from penis? NO YES Difficulty starting/maintaining erections? NO YES Prostate Problems? NO YES FOR WOMEN ONLY: Age when period started years old Frequency of periods: Every days Length of each period NO YES Number of deliveries? Abnormal discharge or odor? NO YES NO YES Painful intercourse? NO YES Painful intercourse? NO YES Pink HEMATOLOGICAL: Anemia? NO YES Excessive bleeding? NO YES Excessive bleeding? NO YES Excessive bleeding? NO YES ENDOCRINE (Hormone):  ENDOCRINE (Hormone):  NO YES  ENDOCRINE (Hormone):  Thyroid disease? NO YES Intolerance to mildly warm or mildly Temperatures? NO YES Change in texture of hair or skin? NO YES Significant change in voice? NO YES Significant change in shoe size NO YES Number of pregnancies? NO YES Number of deliveries? NO YES  Normal discharge or odor? NO YES Painful intercourse? NO YES Painful intercourse? NO YES				a psychiatrist?	NO	YES
Kidney stones? NO YES Unexplained bruising? NO YES EXCESSIVE bleeding? NO YES Difficulty starting urination? NO YES Decrease in strength of urine stream NO YES Discharge from penis? NO YES Difficulty starting/maintaining erections? NO YES Difficulty starting urination? NO YES Difficulty starting urination? Discharge from penis? NO YES Difficulty starting urination? NO YES Difficulty starting menis? NO						
Unexplained bruising? NO YES  Excessive bleeding? NO YES  Difficulty starting urination? NO YES  Decrease in strength of urine stream NO YES  Discharge from penis? NO YES  Difficulty starting/maintaining erections? NO YES  Difficulty starting/maintaining erections? NO YES  Prostate Problems? NO YES  FOR WOMEN ONLY:  Age when period started years old  Frequency of periods: Every days  Length of each period NO YES  Number of pregnancies? NO YES  Number of deliveries? Date of last Pap Smear? Abnormal discharge or odor? NO YES  Painful intercourse? NO YES  Painful intercourse? NO YES  Unexplained bruising? NO YES  Excessive bleeding? NO YES  ENDOCRINE (Hormone):  NO YES  Hormone therapy? NO YES  Thyroid disease? NO YES  Intolerance to mildly warm or mildly  Temperatures? NO YES  Change in texture of hair or skin? NO YES  Crave large amounts of fluids? NO YES  Significant change in shoe size NO YES  NO YES  NO YES  Height Ideal Weight				· · · · · · · · · · · · · · · · · · ·		
FOR MEN ONLY:  Difficulty starting urination?  NO YES  Decrease in strength of urine stream NO YES  Discharge from penis?  NO YES  Difficulty starting/maintaining erections?  NO YES  Prostate Problems?  NO YES  Prostate Problems?  NO YES  Prostate Problems?  NO YES  Prostate Problems?  NO YES  Change in texture of hair or skin?  Age when period started years old  Frequency of periods: Every days  Length of each period NO YES  Number of pregnancies?  Number of deliveries?  Date of last Pap Smear?  Abnormal discharge or odor?  NO YES  ENDOCRINE (Hormone):  Hormone therapy?  NO YES  Thyroid disease?  NO YES  Change in texture of hair or skin?  NO YES  Crave large amounts of fluids?  NO YES  Significant change in shoe size  NO YES  NO YES  No YES  Height Ideal Weight  Extremely painful periods?  NO YES  Painful intercourse?  NO YES	Kidney stones?	NO	YES			
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Discharge from penis? NO YES Difficulty starting/maintaining erections? NO YES Prostate Problems? NO YES Prostate Problems? NO YES Difficulty starting/maintaining erections? NO YES Prostate Problems? NO YES Thyroid disease? NO YES Intolerance to mildly warm or mildly Temperatures? NO YES Change in texture of hair or skin? NO YES Age when period started years old Change in voice? NO YES Frequency of periods: Every days Length of each period Significant change in shoe size NO YES Number of pregnancies? NO YES Number of deliveries? Date of last Pap Smear? Abnormal discharge or odor? NO YES Painful intercourse? NO YES Painful intercourse? NO YES						
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Prostate Problems?  NO YES  Intolerance to mildly warm or mildly  Temperatures?  NO YES  FOR WOMEN ONLY:  Age when period started years old Frequency of periods: Every days Length of each period Significant change in shoe size Number of pregnancies? Number of deliveries?  Date of last Pap Smear?  Extremely painful periods? NO YES  Height Ideal Weight  Extremely painful periods? NO YES  Height Ideal Weight  Extremely painful intercourse? NO YES						
Temperatures? NO YES  FOR WOMEN ONLY: Age when period started years old Frequency of periods: Every days Length of each period Significant change in shoe size No YES  Painful intercourse? No YES  No YES  No YES  No YES					NO	YES
FOR WOMEN ONLY:  Age when period started years old  Frequency of periods: Every days  Length of each period Significant change in shoe size  NO YES  No YES  No YES  No YES  No YES  No YES  Number of pregnancies? Severe fatigue? NO YES  Number of last Pap Smear? Abnormal discharge or odor? NO YES  Painful intercourse? NO YES  No YES  Height Ideal Weight September Severe Se	Prostate Problems?	NO	YES		NO	TADO.
Age when period started years old						
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Date of last Pap Smear?				Severe fatigue?	NO	YES
Abnormal discharge or odor? NO YES Height Ideal Weight  Extremely painful periods? NO YES  Painful intercourse? NO YES			_			
Extremely painful periods? NO YES Painful intercourse? NO YES			—	TT - 1.	1337 * 1 :	
Painful intercourse? NO YES				Height Ideal	Weight _	
Breast lumps or pain? NO YES Signature:				G'		
	Breast lumps or pain?	NO	1 ES	Signature:		