**FAMILY HISTORY:** Has anyone in your family ever had the following:

| | | Condition | Relationship | | | Condition | Relationship |
|---|---|---|---|---|---|---|---|
| Y | N | Heart Condition | ______ | Y | N | Diabetes | ______ |
| Y | N | Epilepsy | ______ | Y | N | Thyroid Disease | ______ |
| Y | N | Stroke | ______ | Y | N | Cancer | ______ |
| Y | N | Asthma | ______ | Y | N | Colitis | ______ |
| Y | N | Bleeding Tendencies | ______ | Y | N | High Blood Pressure | ______ |

**MARITAL STATUS**:_____Married _____Divorced _____Single
Spouse: _____Alive _____Deceased

**HABITS:**
Do you now or have you ever smoked? Y N How much/many?____________ How long?____________
Do you drink alcohol? Y N How much?____________ How long?____________
Do you now or have you ever used illicit drugs? Y N

**SYSTEM REVIEW:** Please check any problems which apply to you at this time:

**GENERAL**
Weakness ______
Fatigue ______
Fever ______
Recent Weight Gain ______
Recent Weight Loss ______

**EYES**
Blurred Vision ______
Double Vision ______
Eye Drainage ______
Eye Redness ______
Eye Exam ______

**HEAD, EARS, NOSE & THROAT**
Headache ______
Ear Pain ______
Ear Drainage ______
Decreased Hearing ______
Nasal Congestion ______
Throat Pain ______
Hoarseness ______
Change of Voice ______

**CARDIOVASCULAR**
Chest Pain/Tightness ______
Irregular Heartbeat ______
Heart Murmur ______
Passing Out ______

**LUNGS**
Shortness of Breath ______
Cough ______
Difficulty Breathing ______
Wheezing ______

**DERMATOLOGICAL**
Skin Rash ______
Acne ______
Skin Itching ______
Moles ______

**GASTROINTESTINAL**
Nausea ______
Vomiting of Blood ______
or Black Material ______
Yellow Jaundice ______
Blood in Stool ______
Heartburn ______

**GENITOURINARY**
Incontinence ______
Difficulty Urinating ______
Burning with Urine ______
Blood in Urine ______
Discharge (Penis) ______

**GYNECOLOGICAL**
Vaginal Dryness ______
Vaginal Bleed ______
Last Menstrual
Period ______

**MUSCLE/JOINT/SKELETAL**
Morning Stiffness ______
How Long? ______
Joint Swelling/Pain ______
Joint Affected? ______
Muscle Spasm ______

**NEUROLOGICAL**
Weakness ______
Headache ______
Dizziness ______
Fainting ______
Memory Loss

**ENDOCRINOLOGICAL**
Dry Skin ______
Coarse Hair ______
Early Menstrual ______
Cold/Heat Intolerance ______

**SCREENING PROCEDURE**
Date of Last Treadmill? ______
Date of Last EKG? ______
Date of Last Chest Xray? ______
Date of Last Pap Smear? ______
Date of Last Mammo? ______
Date of Last Colonoscopy? ______

**Do you have a living will? Yes or No**

I certify that the above information is true and accurate.

**Signature:** ______________________ **Date:** ______________