

Name _____

Date of Birth _____

Check the box if you or any immediate family member ever been told you have:
Self Family

- Cancer.....
- Diabetes.....
- High blood pressure.....
- Heart disease.....
- Angina / chest pain.....
- Stroke.....
- Lung problems.....
- Osteoporosis.....
- Osteoarthritis.....
- Rheumatoid arthritis.....

Blood type:
Dominate side: (circle one) L R
Ambidextrous

- Conditions**
- Anemia.....
 - Anorexia.....
 - Chemical dependency...
 - HIV.....
 - Hepatitis.....
 - Hernia.....
 - Kidney stones.....
 - Liver disease.....
 - Multiple sclerosis.....
 - CVA.....
 - TIA.....
 - Tuberculosis.....
 - Phlebitis.....
 - Gout.....

- GYN**
- Irregular menstrual flow...
 - Profuse menstrual flow...
 - Breast soreness.....
 - Breast lumps.....
 - Vaginal discharge.....
 - PMS.....

- Urology**
- Bladder impairment.....
 - Prostatitis.....
 - Frequency.....
 - Burning on urination.....
 - Colitis.....

- Muscular / Bone / Joints**
Pain weakness, numbness, swelling, stiffness or loss of coordination:
- Arms.....
 - Hips.....
 - Face.....
 - Legs.....
 - Feet.....
 - Neck.....
 - Hands.....
 - Fingers.....
 - Shoulders.....
 - Toes.....
 - Knees.....
 - Ankles.....
 - Mid Back.....
 - Low Back.....
 - Upper Back.....
 - Jaw.....
 - Elbows.....

- Skin**
- Easy bruising.....
 - Hives.....
 - Open areas on skin.....
 - Dermatitis.....
 - Eczema.....
 - Rash.....
 - Warm skin.....
 - Cold skin.....

- Respiratory**
- Emphysema.....
 - Chronic Sinusitis.....
 - Chronic Bronchitis.....
 - Chronic cough.....

- General:**
- Depression.....
 - Fainting.....
 - Fatigue.....
 - Heartburn.....
 - Night pain.....

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes No

Have you fallen in the past year? Yes No

Did you sustain an injury? Yes No

Are you afraid you will fall? Yes No

Do you frequently need to use the arms of the chair to rise? Yes No

Are you currently:
Pregnant.....yes no
Under stress.....yes no

How are you able to sleep at night? (circle one)
Fine Moderate difficulty Only with medication

Sleeping positions: (circle all that apply)
Prone Supine Left side right side

Do you have a problem with...(circle answers)
Hearing Speech Vision

Do you or have you smoked tobacco?
Yes No
If yes, _____packs per day for _____years
(amount and # of packs) (# of years)

Do you drink alcoholic beverages?
Yes No
If yes, _____drinks per day / week / month
(amount and # of drinks) (circle one above)

Do you drink coffee or tea?
Yes No
If yes, _____drinks per day / week / month
(amount and # of drinks) (circle one above)

Do you drink any other caffeinated beverages?
Yes No
If yes, _____drinks per day / week / month
(amount and # of drinks) (circle one above)

Do you drink plain water?
Yes No
If yes, _____glasses per day
(amount and # of drinks)

Check the box if you have a history of:

- A change in your health.....
- Nausea / vomiting.....
- Fever / chills.....
- Unexplained weight change...
- Numbness or tingling.....
- Changes in appetite.....
- Difficulty swallowing.....
- Changes in bowel or bladder function.....
- Shortness of breath.....
- Dizziness.....
- Upper respiratory infection.....
- Urinary tract infection.....
- Asthma.....
- Back problems.....
- Excessive thirst.....
- Headaches.....
- Bronchitis.....
- General fatigue.....
- Kidney disease.....
- Neck pain.....
- Rheumatic fever.....
- Ulcers.....
- Sexually transmitted disease...
- Seizures.....

- ENT**
- Blurred vision.....
 - Double vision.....
 - Ear aches.....
 - Hoarseness.....
 - Nose bleeds.....
 - Ringing in ears.....
 - Cataracts.....
 - Glaucoma.....
 - Impaired vision with glasses....
 - Impaired hearing.....
 - do you wear hearing aids.....

- Cardiovascular**
- Chest pain.....
 - Elevated cholesterol.....
 - Rapid heart beat.....
 - Varicose veins.....
 - History of MI.....
 - Pacemaker.....
 - Cardiac Surgery.....
 - Circulation problems.....