
Please circle below only if you have had any of the following health problems:

Eyes: cataracts glaucoma macular degeneration diabetic eye disease loss of vision

Ears: deafness decreased hearing history of frequent ear infections

Respiratory: frequent nose bleeds nasal allergies chronic sinus problems

Lungs: asthma collapsed lung emphysema blood clots in lung positive skin test for tuberculosis

Heart: high blood pressure heart attack angina heart valve problem congestive heart failure
heart rhythm problem

GI Tract: hiatal hernia ulcer irritable bowel syndrome colitis diverticulitis chronic constipation
colon polyps

Biliary: hepatitis gallstones liver problems

Urinary: recurrent infections kidney stones problems controlling urine

Male: prostate trouble erectile dysfunction

Female: menopausal symptoms menstrual problems breast cysts

Muskuloskeletal: gout rheumatoid arthritis Lupus fibromyalgia osteoporosis

Neurological: seizures Parkinson's disease multiple sclerosis stroke migraines

Hormonal: diabetes thyroid problems high cholesterol

Mental Health: major depression chronic anxiety manic-depressive (bipolar) illness
schizophrenia Alzheimer's disease

Cancer: breast lung colon prostate other (please describe): _____

Circle if you have noticed in the last year:

Loss of appetite
Unusual fatigue
>10 pound weight change
Change in skin or nails
Change in vision
Change in hearing
Change in breathing
Chronic cough

Breathlessness with exertion
Palpitations
Swollen ankles
Worrisome abdominal pain
Constipation or diarrhea
Blood in stools
Bad heartburn
Problems controlling urine

Numbness in hands or feet
Tremor
Trouble concentrating
Worrying too much
Depression
Problems with alcohol
Increased irritability
Insomnia

Wheezing
Worrisome chest pain

Back pain
Frequent headaches

Loss of interest in sex

Circle if you have regularly used: cigarettes cigars pipe chewing tobacco/snuff
If a smoker, how many packs per day? _____ How long have you used tobacco products? _____
If you have stopped, how long ago? _____ Are you interested in tobacco cessation? _____

Circle if you regularly drink: beer wine alcohol

Date of last Td (tetanus) shot: _____

Please list if an immediate family member (Parents or Brothers/Sisters) has had a history of the following health problems:

	(relationship)	(age it began)
High blood pressure	_____	_____
Diabetes	_____	_____
Obesity	_____	_____
High Cholesterol	_____	_____
Heart Attack	_____	_____
Stroke	_____	_____
Breast Cancer	_____	_____
Colon Cancer	_____	_____
Prostate Cancer	_____	_____
Ovarian Cancer	_____	_____
Other Cancers (list)	_____	_____
Alzheimer's	_____	_____
Thyroid Problems	_____	_____
Mental Illness	_____	_____

What is your occupation? _____

Are you retired? Y N

Marital Status: _____

Do you have children? Y N If so, how many? _____

Are there any other details regarding your health history we should know about? If so, please describe briefly below:

Thank you for completing your health history form. Please return this form to us so we may enter your data into our records. If you have any questions about how to complete this form, please let us know. Thanks