

PERSONAL HISTORY:

CANCER SCREENING:

Have you had a:

Mammogram Y N please give approximate date _____
Gynecologic exam/Paps smear Y N please give approximate date _____
Colonoscopy Y N please give approximate date _____
Prostate exam/PSA Y N please give approximate date _____

Do you:

Smoke Y N-if so, Packs per day _____ or quit smoking _____ years ago
Consume Alcohol Y N-if so, # drinks per week _____ or were you ever a heavy drinker Y N
Quit drinking _____ years ago

Have you ever had:

Any Asbestos Exposure Y N Other Toxin Exposure Y N (please list) _____

Please List:

Present Occupation _____ Previous Occupation _____

Marital Status _____ With whom do you live? _____

REVIEW OF SYSTEMS:

ARE YOU EXPERIENCING ANY OF THE FOLLOWING:

Frequent headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N
Changes in vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N
Sinus problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Ear problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Weight loss # _____ lbs	<input type="checkbox"/> Y <input type="checkbox"/> N	Weight gain	<input type="checkbox"/> Y <input type="checkbox"/> N
Sleep problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Heavy night sweats	<input type="checkbox"/> Y <input type="checkbox"/> N
Nervousness	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Appetite problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Fevers	<input type="checkbox"/> Y <input type="checkbox"/> N
Painful /stiff neck	<input type="checkbox"/> Y <input type="checkbox"/> N	Sore throats	<input type="checkbox"/> Y <input type="checkbox"/> N
Thyroid problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Trouble swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N
Bronchitis/emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> N
Coughing blood	<input type="checkbox"/> Y <input type="checkbox"/> N	Chronic cough	<input type="checkbox"/> Y <input type="checkbox"/> N
Pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> N	Chest pains	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Palpitations	<input type="checkbox"/> Y <input type="checkbox"/> N
Angina	<input type="checkbox"/> Y <input type="checkbox"/> N	Rapid heart beat	<input type="checkbox"/> Y <input type="checkbox"/> N
Acid indigestion/heartburn	<input type="checkbox"/> Y <input type="checkbox"/> N	Nausea/vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N
Gallstones	<input type="checkbox"/> Y <input type="checkbox"/> N	Diarrhea/constipation	<input type="checkbox"/> Y <input type="checkbox"/> N
Pains in abdomen	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood in stool	<input type="checkbox"/> Y <input type="checkbox"/> N
Hemorrhoids	<input type="checkbox"/> Y <input type="checkbox"/> N	Back pain	<input type="checkbox"/> Y <input type="checkbox"/> N
Liver problems/jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney infections	<input type="checkbox"/> Y <input type="checkbox"/> N
Kidney stones	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood in urine	<input type="checkbox"/> Y <input type="checkbox"/> N
Bladder infections	<input type="checkbox"/> Y <input type="checkbox"/> N	Prostate problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Frequent urination	<input type="checkbox"/> Y <input type="checkbox"/> N	Waking up to urinate	<input type="checkbox"/> Y <input type="checkbox"/> N
Slow urine stream	<input type="checkbox"/> Y <input type="checkbox"/> N	Pain/stiff joints	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke/TIA's	<input type="checkbox"/> Y <input type="checkbox"/> N
Epilepsy/seizures	<input type="checkbox"/> Y <input type="checkbox"/> N	Vision loss	<input type="checkbox"/> Y <input type="checkbox"/> N
Brief weakness of hand or leg	<input type="checkbox"/> Y <input type="checkbox"/> N	Bleeding easily	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Moles changing color/size	<input type="checkbox"/> Y <input type="checkbox"/> N
Easy bruising	<input type="checkbox"/> Y <input type="checkbox"/> N	Any skin rashes	<input type="checkbox"/> Y <input type="checkbox"/> N
Prior blood transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N	Irregular menstrual cycle	<input type="checkbox"/> Y <input type="checkbox"/> N
Heavy menstrual flow	<input type="checkbox"/> Y <input type="checkbox"/> N		
Severe Menstrual Cramps	<input type="checkbox"/> Y <input type="checkbox"/> N		