Patient Name ____

Age ____ Sex ________________________

Employer ____

Occupation ____ Marital Status _____________________

Number of Children _____________ Age and sex ____

Do you see a cardiologist or other specialist? ____Yes ____ No Physician's Name _______________________

Have you ever been in the hospital with or without surgery? ____ Yes ____ No

When and why were you hospitalized? ____

____

____

What medications are you taking? (Name and dose if known) ____

____

____

Preferred Pharmacy ____

How much do you smoke? _____________packs/day _____________Do not smoke

What are you allergic to? ____

How much alcohol do you drink? ______ (cans/glasses/drinks) of (beer/wine/liquor) per (day/week/month)

Has anyone in your family or yourself had:

Lung disease? (asthma, emphysema, bronchitis, other ___________________) Who? ________________

Heart disease? …………………………………………………………………. Who? ________________

Liver disease? …………………………………………………...…………….. Who? ________________

Kidney disease? ………………………………………………………………. Who? ________________

High blood pressure? …………………………………………………………. Who? ________________

Stroke? …………………………………………………………………………Who? ________________

Arthritis? ………………………………………………………………………Who? ________________

Cancer:

Lung? …………………………………………………………………Who? ________________

Liver? ………………………………………………………………… Who? ________________

Bowel? ……………………………………………………………….. Who? ________________

Prostate? …………………………………………………………….. Who? ________________

Breast? ………………………………………………………………... Who? ________________

Thyroid? …………………………………………………………….. Who? ________________

Kidney? ……………………………………………………………… Who? ________________

Pancreas? ……………………………………………………...….Who? ________________

Leukemia? …………………………………………………………. Who? ________________

Other? ____________________……………………………… Who? ________________

Diabetes? ……………………………………………………………………..Who? ________________

Tuberculosis? …………………………………………………………………. Who? ________________

Have you ever had:

Difficulty seeing other than with reading glasses?	Yes	No
Difficulty hearing?	Yes	No
Balance problems?	Yes	No
Dizziness?	Yes	No
Ringing in your ears?	Yes	No
Difficulty swallowing?	Yes	No
Hoarseness?	Yes	No
Goiter?	Yes	No
Repeated bloody nose?	Yes	No
Difficulty smelling?	Yes	No
Shortness of breath?	Yes	No
To sleep on 2 or 3 pillows?	Yes	No
Difficulty walking up stairs?	Yes	No
Chest pain or pressure?	Yes	No
Chest tightness?	Yes	No
Chronic nausea?	Yes	No
Chronic heartburn?	Yes	No
Chronic need for antacids?	Yes	No
Chronic constipation?	Yes	No
Blood in stools, either red or black?	Yes	No
Chronic diarrhea?	Yes	No
Hemorrhoids?	Yes	No
Blood in urine?	Yes	No
Difficulty urinating?	Yes	No
Uncontrolled loss of urine?	Yes	No
Uncontrolled loss of bowel contents?	Yes	No
Kidney stones?	Yes	No
Bladder infections?	Yes	No
Prostate problems?	Yes	No
Menstrual problems?	Yes	No
Chronic or persistent headaches?	Yes	No
Seizures?	Yes	No
Passing out?	Yes	No
Gout?	Yes	No
Curvature of spine?	Yes	No
Aids?	Yes	No