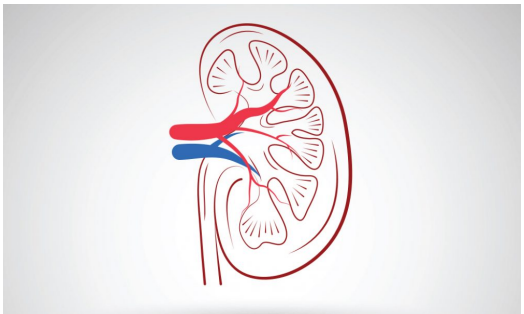

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Health Questionnaire

Last Name:_____ **First Name:**_____

Symptoms (Please check all that apply)

General

- ❑ Fever
- ❑ Chills
- ❑ Sweats
- ❑ Insomnia
- ❑ Leg Swelling
- ❑ Weight Loss
- ❑ Dizziness

Cardiovascular

- ❑ Chest Pain
- ❑ Palpitations
- ❑ Rapid Heart Rate
- ❑ Shortness of Breath
- ❑ Orthopnea
- ❑ Fatigue

Muscle/Bone/Joint

- ❑ Joint Swelling
- ❑ Muscle Weakness
- ❑ Other List

_____
_____
_____

Gastrointestinal

- ❑ Anorexia
- ❑ Nausea
- ❑ Vomiting
- ❑ Loose Stools
- ❑ Blood in Stool
- ❑ Constipation
- ❑ Reflux

Genito-Urinary

- ❑ Painful Urination
- ❑ Poor Urine Stream
- ❑ Incontinence
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Foamy Urine

Health Conditions (Please check all that apply)

❑ AIDS (HIV disease)	❑ GallStones	❑ Heart Disease	❑ Jaundice	❑ Kidney Stones
❑ Bleeding Problems	❑ TB	❑ Incontinence	❑ Prostate Problems	❑ Stroke
❑ High Cholesterol	❑ Diabetes	❑ Arthritis	❑ Asthma	❑ Allergies
❑ Kidney Failure	❑ Anemia	❑ Cancer	❑ COPD (emphysema)	❑ Cataracts
❑ Organ Transplant	❑ Bronchitis	❑ Glaucoma	❑ Goiter	❑ Gout
❑ Thyroid Disease	❑ Epilepsy	❑ Hepatitis	❑ High Blood Pressure	❑ Headaches
❑ Kidney Infections	❑ List Others _____			

List of Medications with Dosage and Frequency

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Family Medical History

Relation	Age	State of Health	Age of Death	Cause of Death	Circle if blood relatives have the following	Relationship
Father					Hypertension	
Mother					Kidney Disease	
Brother(s)					Heart Disease	
					Cancer	
					Arthritis	
					Gout	
Sister(s)					Diabetes	
					Asthma	

Hospitalizations (including pregnancies and operations)

Year	Hospital	Reason for Hospitalization
_____	_____	_____
_____	_____	_____

Allergies (Please List)

_____

Habits (check which substances you use and indicate how much)

- ❑ Tobacco *How much*_____ *How often*: _____ *if you Quit when* _____
- ❑ Alcohol *How much*_____ *How often*: _____ *if you Quit when* _____
- ❑ Caffeine (Coffee) *How much*_____ *How often*: _____ *if you Quit when* _____
- ❑ Other Drugs *How much*_____ *How often*: _____ *if you Quit when* _____