**PLEASE COMPLETE & BRING TO APPOINTMENT**

***Advanced Medical Care***

***Complete Physical Form and Questionnaire***

Salutation: Mr. \_\_\_ Mrs. \_\_\_ Ms. \_\_\_ Dr. \_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_

Current Medical History

What would you regard as your main medical problem or chief concern that you would like addressed during your physical exam?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History or Illnesses

Diabetes: \_\_\_\_\_ Hypertension: \_\_\_\_\_ Accidents/Injuries: \_\_\_\_\_

Muscular/Skeletal Complaints: \_\_\_\_\_ Hypothyroidism: \_\_\_\_\_ COPD: \_\_\_\_\_

Surgical Hospitalizations (Please include dates)

1.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Hospitalizations (Please include Dates and Reason for Hospitalizations)

1.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

***Mother: Father: Spouse:***

Deceased(?)\_\_\_\_\_ Deceased(?)\_\_\_\_\_ Deceased(?)\_\_\_\_\_

Medical Problems: Medical Problems: Medical Problems:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Sister: Brother: Son: Daughter***

Deceased(?)\_\_\_\_\_ Deceased(?)\_\_\_\_\_ Deceased(?)\_\_\_\_\_ Deceased(?)\_\_\_\_\_

Medical Problems: Medical Problems: Medical Problems: Medical Problems:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any family history of the following current or past medical conditions in your family?

**Medical Conditions** **Patient or Relative**

Asthma: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COPD: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Attack: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep Apnea: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Assessment**

1. **Alcohol**

What is your approximate weekly intake of the following:

Glasses of wine: \_\_\_\_\_ Beer: \_\_\_\_\_ Oz. of liquor: \_\_\_\_\_

1. **Tobacco**

Do you smoke cigarettes? \_\_\_\_\_\_

If yes, how many years have your smoked? \_\_\_\_\_\_\_\_

If you quit, when did you quit? \_\_\_\_\_\_\_\_

What form of tobacco do you use, if not cigarettes. (Please circle)

Pipe Chewing tobacco Vape Cigars

1. **Recreation Drugs**

Do you use recreational drugs? \_\_\_\_\_\_\_\_

If yes, what type do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Sexual History**

Would you describe your sexual life as satisfactory or unsatisfactory (Please circle one)

What the number of sexual contacts in your lifetime? \_\_\_\_\_

What is your sexual preference? \_\_\_\_\_\_\_\_\_\_

1. **Religion**

What is your faith? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you participate in your faith? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Physical Activity:**

How often do you exercise: Never\_\_\_\_\_ Intermittently\_\_\_\_\_ Regularly\_\_\_\_\_

How would you characterize the intensity of your exercise:

Low \_\_\_\_\_ Medium \_\_\_\_\_ High \_\_\_\_\_

How many hours per week do you do the following exercises or sports?

Jogging\_\_\_\_\_ Bicycle Riding\_\_\_\_\_ Tennis\_\_\_\_\_ Weight training\_\_\_\_\_

Walking\_\_\_\_\_ Swimming\_\_\_\_\_ Treadmill\_\_\_\_\_ Golf\_\_\_\_\_

Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Nutrition**

How many times a week do you eat the following:

Beef: \_\_\_\_\_ Pork: \_\_\_\_\_ Poultry: \_\_\_\_\_ Fish: \_\_\_\_\_

How much milk do you drink daily: \_\_\_\_\_\_\_\_

Is it whole, 1%, 2%, skim, or other\_\_\_\_\_\_\_\_\_

What is your daily intake of the following:

Cups of coffee \_\_\_\_\_ Cups of tea \_\_\_\_\_ Cups of water \_\_\_\_\_ Cans of soda \_\_\_\_\_

Are you satisfied with your nutrition intake? \_\_\_\_\_\_\_\_\_\_

If not, what you would you like to change? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Social History:**

Are you: Single\_\_\_ Married\_\_\_ Divorced\_\_\_ Widowed\_\_\_

How many hours of sleep do you average each night \_\_\_\_\_\_\_\_\_\_

Do you have difficulty sleeping? Yes\_\_\_ No\_\_\_

What is your occupation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you spend alone time with “loved ones”? (ie spouse and children

1. **Weight:**

Lowest Adult weight: \_\_\_\_\_\_ Highest Adult Weight: \_\_\_\_\_\_ Your goal weight: \_\_\_\_\_\_

Have you had any significant weight gain in the past year? Yes \_\_\_ No \_\_\_

Have you had any significant weight loss in the past year? Yes \_\_\_ No \_\_\_

Have you had any significant weight gain in the past 5 years? Yes \_\_\_ No \_\_\_

Are you taking any prescription medication to lose weight? Yes \_\_\_ No \_\_\_

**Body System Review:**

**General:**

How do you feel physically and in general?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience any fatigue or weakness? Yes \_\_\_ No \_\_\_

Do you suffer from fevers or night sweats? Yes \_\_\_ No \_\_\_

**Skin:**

Do you have rashes, lesions or acne? Yes \_\_\_ No \_\_\_

**Head:**

Have you ever experienced a loss of consciousness? Yes \_\_\_ No \_\_\_

**Eyes:**

Do you have cataracts, glaucoma or double vision? Yes \_\_\_ No \_\_\_

Have you experienced any type of hearing changes? Yes \_\_\_ No \_\_\_

Have you noticed any vision changes? Yes \_\_\_ No \_\_\_

**Ears:**

Have you experienced any type of hearing changes? Yes \_\_\_ No \_\_\_

Have you noticed any “ringing” in your ears? Yes \_\_\_ No \_\_\_

**Nose:**

Does your nose bleed often? Yes \_\_\_ No \_\_\_

Do you have sinusitis or nasal polyps? Yes \_\_\_ No \_\_\_

**Throat:**

Do you have lesions, soreness or hoarseness? Yes \_\_\_ No \_\_\_

Do you have difficulty swallowing? Yes \_\_\_ No \_\_\_

**Breast:**

Have you had any masses? Yes \_\_\_ No \_\_\_

Do you have fibrocystic breast conditions? Yes \_\_\_ No \_\_\_

Have you noticed discharge from your nipples? Yes \_\_\_ No \_\_\_

Have you ever had an abnormal mammogram? Yes \_\_\_ No \_\_\_

**Gastro-Intestinal:**

Have you experienced any changes in your mouth or teeth? Yes \_\_\_ No \_\_\_

Do you have any abdominal pain, bloating, or gas? Yes \_\_\_ No \_\_\_

Have you had any changes in your stool or bowel habits? Yes \_\_\_ No \_\_\_

Do you have frequent diarrhea or constipation? Yes \_\_\_ No \_\_\_

Do you have hemorrhoids? Yes \_\_\_ No \_\_\_

Have you noticed any rectal bleeding? Yes \_\_\_ No \_\_\_

Do you experience frequent nausea or vomiting? Yes \_\_\_ No \_\_\_

Do you have hepatitis or jaundice? Yes \_\_\_ No \_\_\_

Do you have a hernia? Yes \_\_\_ No \_\_\_

**Cardio/Respiratory:**

Do you have a cough? Yes \_\_\_ No \_\_\_

Do you have asthmatic episodes? Yes \_\_\_ No \_\_\_

Have you noticed any “wheezing” when breathing? Yes \_\_\_ No \_\_\_

Do you have chest pain or palpitations? Yes \_\_\_ No \_\_\_

Do you have problems breathing? Yes \_\_\_ No \_\_\_

Do you cough up blood? Yes \_\_\_ No \_\_\_

Do you have swelling in legs? Yes \_\_\_ No \_\_\_

**Genitourinary:**

Do you have urinary frequency? Yes \_\_\_ No \_\_\_

Do you experience burning or painful sensation when urinating Yes \_\_\_ No \_\_\_

Do you experience post void dribbling or urination in the night? Yes \_\_\_ No \_\_\_

Is there reddish color to your urine? Yes \_\_\_ No \_\_\_

Do you have genital discharge, lesions, or warts? Yes \_\_\_ No \_\_\_

Do you experience impotence? Yes \_\_\_ No \_\_\_

**Menstrual/Reproductive:**

How old were you when you had your first period? \_\_\_\_\_\_\_\_\_\_

Are your periods regular or irregular? \_\_\_\_\_\_\_\_\_\_

How many days between your periods? \_\_\_\_\_\_\_\_\_\_

How many days do your periods last? \_\_\_\_\_\_\_\_\_\_

Do you experience pain or cramping during your period? Yes \_\_\_ No \_\_\_

Do you experience vaginal discharge or itching? Yes \_\_\_ No \_\_\_

Do you have “hot flashes”? Yes \_\_\_ No \_\_\_

Do you have vaginal dryness? Yes \_\_\_ No \_\_\_

Are you taking hormone replacement therapy? Yes \_\_\_ No \_\_\_

Have you ever had an abnormal pap smear? Yes \_\_\_ No \_\_\_

If yes, when? \_\_\_\_\_\_\_\_\_\_

**Endocrine:**

Do you experience excessive thirst? Yes \_\_\_ No \_\_\_

Do you eat large amounts of food? Yes \_\_\_ No \_\_\_

Do you have any thyroid difficulties? Yes \_\_\_ No \_\_\_

Do you experience intolerance with temperature? Yes \_\_\_ No \_\_\_

Are you currently undergoing hormonal treatment? Yes \_\_\_ No \_\_\_

**Hematology:**

Have you ever been anemic? Yes \_\_\_ No \_\_\_

Do you tend to bleed or bruise easily? Yes \_\_\_ No \_\_\_

**Back, Joints and Extremities:**

Do you experience pain or stiffness? Yes \_\_\_ No \_\_\_

Do you have any limitations in your extremities Yes \_\_\_ No \_\_\_

Do you have any swelling in your joints? Yes \_\_\_ No \_\_\_

Do you have arthritis? Yes \_\_\_ No \_\_\_

**Neuro/Psych.**

Have you ever experienced depressions or mood swings? Yes \_\_\_ No \_\_\_

Do you have frequent headaches? Yes \_\_\_ No \_\_\_

Do you have migraines? Yes \_\_\_ No \_\_\_

Do you suffer from insomnia? Yes \_\_\_ No \_\_\_

Do you experience vertigo? Yes \_\_\_ No \_\_\_

Have you ever had convulsions? Yes \_\_\_ No \_\_\_

Have you experienced tremors? Yes \_\_\_ No \_\_\_

Have you ever had numbness or tingling feeling? Yes \_\_\_ No \_\_\_

Do you ever feel nervous or anxious? Yes \_\_\_ No \_\_\_

If yes, how long do these episodes last? \_\_\_\_\_\_\_\_\_\_

**Immunizations:**

Has it been more than 10 years since your last tetanus vaccine? Yes \_\_\_ No \_\_\_

Have you ever had a pneumonia vaccine? Yes \_\_\_ No \_\_\_

Do you get a flu shot every year? Yes \_\_\_ No \_\_\_