

Physical Form

Date: _____

Name: _____ Age _____

1. Have you had any of the following problems:

- a. High blood pressure Y N
- b. Heart disease Y N
- c. Cancer Y N
- d. High cholesterol Y N
- e. Diabetes Y N

2. In the last 6 months have you experience:

- A. Pain or pressure in your chest? Y N
- B. Palpitations or pounding heart? Y N
- C. Frequent indigestion or heartburn? Y N
- D. Difficulty Swallowing? Y N
- E. A change in bowel or bladder habits? Y N
- F. Blood in or on stool, black, tarry stools? Y N
- G. Frequent urination? Y N
- H. Difficult with urine stream Y N
- I. Arthritis, rheumatism or joint pains? Y N
- J. Back pain? Y N
- K. A sore that does not heal? Y N
- L. A thickening or lump in breast or else where? Y N
- M. Unrecent gain or loss of 10 lbs or more of weight? Y N
- N. Frequent or severe Headaches? Y N
- O. Dizzy spells, fainting, or blackouts? Y N
- P. Eye Trouble or vision problems? Y N
- Q. Difficulty with your hearing? Y N
- R. Hoarseness of your voice? Y N
- S. Wheezing or shortness of breath Y N
- T. Chronic cough? Y N
- U. Coughing up blood? Y N
- V. Obvious change (color/size) in a mole or wart? Y N
- W. Felt excessively depressed or blue? Y N
- X. Difficulty in relaxing or calming down? Y N

3. Have you ever smoke cigarettes or use tobacco? If so, how much? _____

Numbers of years smoked? _____

When are you planning to quit? _____

If you stopped smoking cigarettes or using Tobacco, when was it? _____

4. Do you drink alcohol beverage? Y N

Have you ever felt you ought to cut

down on your drinking? Y N

Have you even been annoyed by people criticizing your drinking? Y N

Have you ever felt bad or guilty about your drinking? Y N

Have you ever had a morning eye-opener to steady your nerves? Y N

Have you even been a patient in a mental health facility or been treated by a psychiatrist psychologist or mental health doctor? Y N

5 .Do you have a parent, brother or sister with a history of the following:

a. Cancer of the breast, intestine or female organ. If yes, who/what _____ Y N

b. Heart pain or heart attack before the age of 65? If Yes, who _____ Y N

c. Cancer of the prostate or intestine? If yes, who _____ Y N

WOMEN ONLY

First day of your last menstrual cycle _____

1. If you are past menopause, have you had any vaginal bleeding? Y N

2. Any change in your periods, or bleeding between periods? Y N

3. Any vaginal itching or discharge? Y N

4. When was your last Pap test _____

5. Have you ever had a mammogram? Y N
When? _____

6. Bleeding between periods or since periods stopped?

7. Osteoporosis

a. History of any relatives with following: stopping over or losing height as they got older, "thin bones, hip fractures? Y N

b. Have you had any of the following: Height loss, broken hip or wrist, or bone-density test? Y N

c. Do you take any of the following: Steroids (prednisone) more than 1 month, medication for thyroid, seizures or thin bones? Y N

Comments _____

For office use only			
WT: _____	HT: _____	BP: _____	P: _____