MEDICAL HISTORY AND PRESENT MEDICAL CONDITION QUESTIONNAIRE

Name _____ Date _____

In order for you to gain the most benefit from this program, I encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, feel free to leave it blank. Please explain all YES answers at the end of this questionnaire.

PERSONAL MEDICAL HISTORY

Have you have ever had any of the following conditions (circle Y/N)?

1. Y N Allergies
2. Y N Loss of Hearing
3. Y N Asthma
4. Y N Kidney Disease
5. Y N Prostatitis
6. Y N Colitis
7. Y N Hepatitis
8. Y N Liver disease
9. Y N Elivated Liver Enzyme Test
10. Y N Pancreatitis
11. Y N Ulcer
12. Y N Hear Attack
13. Y N Heart Murmur
14. Y N Positive Stress Test
15. Y N Heart Valve Abnormality
16. Y N Angina
17. Y N Heart Failure
18. Y N High Cholesterol
19. Y N High Blood Pressure
20. Y N Arthritis/Rheumatism
21. Y N Loss of consciousness
22. Y N Epilepsy
23. Y N Convulsion/seizures
24. Y N Stroke
25. Y N Diabetes
26. Y N Thyroid Trouble
27. Y N Anemia
28. Y N Eczema
29. Y N Cancer (Including Skin Cancer)
30. Y N Sleep Apnea

Review of Symptoms
Do you currently have or have you recently had any of the following (circle Y/N)?

EYES, EARS NOSE, THROAT

31. Y N Difficulty With Night Vision
32. Y N Change in Vision
33. Y N Blurred or Double Vision
34. Y N Bleeding Gums
35. Y N Frequent Nosebleeds
36. Y N Frequent Sinus Trouble
37. Y N Recent Hoarseness
38. Y N Ringing or Buzzing Ears
39. Y N Earaches

PULMONARY

40. Y N Shortness of Breath
41. Y N Chronic or Frequent Cough
42. Y N Brown/Blood-tinged Sputum
43. Y N Chest Tightness
44. Y N Wheezing

GENITO-URINARY

45. Y N Bladder Trouble
46. Y N Blood in Urine
47. Y N Irregular Vaginal Bleeding
48. Y N Currently Pregnant
49. Y N Difficulty Starting or Stopping Urination
50. Y N Urinating 3 Times per Night
51. Y N Frequent or Painful Urination
52. Y N Problems With Sexual Function

GASTROINTESTINAL

53. Y N Vomited Blood
54. Y N Persistent Diarrhea
55. Y N Persistent Constipation
56. Y N Frequent Abdominal Pain
57. Y N Frequent Nausea
58. Y N Frequent Indigestion/Heartburn
59. Y N Black/Bloody Bowel Movement
60. Y N Hemorrhoids
61. Y N Trouble Swallowing
62. Y N Hernia

CENTRAL NERVOUS SYSTEM

63. Y N Fainting Spells
64. Y N Recurrent Dizziness
65. Y N Frequent Headaches
66. Y N Tremors
67 Y N Memory Loss
68. Y N Loss of Coordination
69. Y N Difficulty Concentrating
70. Y N Numbness/Tingling Extremities

HEART/VASCULAR

71. Y N Palpitation (Irregular Heat Beat)
72. Y N Pain or Discomfort in Chest
73. Y N High Cholesterol
74. Y N Swelling of Feet
75. Y N Leg Pain While Walking
76. Y N Painful Varicose Vein

MUSCULOSKELETAL

77. Y N Back Trouble/Pain
78. Y N Neck Trouble/Pain
79. Y N Joint Injury/Pain/Swelling
80. Y N Carpal Tunnel Syndrome

MISCELLANEOUS

81. Y N Bleeding/Bruising Easily
82. Y N Enlarged Glands
83. Y N Rashes
84. Y N Unexplained Lumps
85. Y N Chronic Fatigue
86. Y N Night Sweats
87. Y N Undesired Weight Loss
88. Y N Snoring
89. Y N Difficulty Sleeping
90. Y N Low Blood Sugar

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Name _____

ADDITIONAL HEALTH AND LIFESTYLE QUESTIONS

Please answer the following questions honestly:

91. Y N Are you experiencing any stresses, mood problems, relationship difficulties, or substance related problems for which you would like resource or referral information on confidential basis?

92. Y N Do you occasionally use or are you currently taking any prescription or over-the-counter medications? List name, dosage, and the reason the medication is used on the next page.

93. Y N Have you had any surgical operations in the last 10 years?

94. Y N Has anyone in your immediate family developed heart disease before the age of 60?

95. Y N Do any diseases run in your family?

96. Y N Do you currently have a cold/cough, or have you had any in the last two weeks?

97. Y N Have you ever been hospitalized? If yes, please list date, length of stay, and length of stay, and reason on the next page.

98. Y N Are you currently under a doctor's care? If yes, please describe what you are being treated for on the next page.

99. Y N Have you had a change in the size or colour of a mole, or a sore that would not heal in the past year?

100. Y N Do you have any special concerns regarding your health that you would like to discuss with the doctor?

101. Y N Are you a current cigarette smoker?
A. How many packs of cigarettes do you smoke a day?
B. How long have you been smoking?

102. Y N Are you an ex-smoker?
A. How many years did you smoke?
B. How many packs a day?
C. When did you quit?

103. Y N Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?

104. I drink ___ beers ___ ounces of hard liquor ___ ounces of wine per week.

105. When were your most recent immunizations? Tetanus _____ Flu Shot _____ Pneumovax _____

106. When were you most recent health maintenance screening tests?
Cholesterol _____ Results? _____ PSA (Prostate) _____ Results? _____ Mammogram _____ Results? _____
Sigmoidoscopy _____ Results? _____ Pap Smear _____ Results? _____

107. Describe any hobbies or recreational activities that have exposed you to noise, chemicals or dust:

108. Please describe typical weekly exercise or physical activities including any exercise at work:

109 My current diet could be best characterized as (check all that apply)
___ Low Fat ___ Low Carb ___ High Protein ___ Vegetarian/Vegan ___ No Special Diet