The Family Practice Center of Sulphur, Inc.
PERSONAL HEALTH SURVEY
(To Be Filled Out By The Patient and/or Relative)
FEMALE

_____ _____
Name of Patient Date of Birth

Yes No

1. Have you had any of the following conditions:
a. Asthma
b. Tuberculosis (TB)
c. Heart trouble
d. High blood pressure
e. Ulcer
f. Gallbladder Trouble
g. Liver trouble, Yellow Jaundice (yellow eyes and skin) or Hepatitis
h. Kidney or bladder trouble
i. Kidney stones
j. Hernia (rupture)
k. Fits or convulsions
l. Sugar diabetes (sugar blood)
m. Syphilis (bad blood)
n. Tumor or cancer
o. Nervous breakdown
p. Blackout (loss of consciousness), fainting or falling out
q. Anemia or sickle cell disease
r. Operation? Describe:_____

Place an "X" for yes if the subject applies to you or has occurred during the past 12 months. If you have <u>not</u> experienced any of these, place an "x" for NO.

2. Have you ever lived in the same house with someone with tuberculosis?
3. Have you taken two or more drinks of alcohol a day?
4. Have you smoked more than a pack of cigarettes a day?
5. Have you had difficulty in trying to fall asleep?
6. Have you recently lost a lot of weight without trying?
7. Do you drink more than three cups of coffee a day?
9. Are you taking any medications on a regular basis?
9. Are there any medications to which you are allergic or cannot take?

E.N.T.

10. Do you often get dizzy and wobbly?
11. Do you have a swelling in your neck?
12 Do your eyes hurt?
13. Do your eyes blur, lasting more than a few minutes or do you see spots?
14. Are you hard of hearing?
15. Have had a roaring or ringing in your ears?

RESPIRATORY AND CARDIOVASCULAR

16. Have you had a painful swelling in your jaw and/or bleeding in your gums?
17. Do you cough a lot now?

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RESPIRATORY AND CARDIOVASCULAR (continued)

Yes No

18. Have you ever spit or coughed up blood?
19. Do you get out of breath easily?
20. Do you prop yourself up or sit up at night to sleep?
21. Have you had frequent pains in your heart or chest?
22. Does your heart palpatate (flutter) or skip?
23. Are your ankles often swollen?
24. Do you get pains or cramps in your legs when you walk?

GASTROINTESTINAL

25. Does it hurt to swallow?
26. Do you have a lot of indigestion?
27. Have you vomited (thrown up) often?
28. Have you vomited blood?
29. Have you had a lot of trouble with constipation?
30. Have you often had diarrhea (loose bowels)?
31. Have you ever had red blood in your bowel movements?
32. Have your bowel movements ever looked like black tar?
33. Does it hurt to move your bowels?
34. Do you tend to eat too much or too little?

GENITO URINARY

35. Do you get up more than two times a night to urinate (pass your water)?
36. Does it burn when you urinate (pass your water)?
37. Do you lose control of your urine (water)?
38. Have you ever had blood in your urine (water)?

GYNECOLOGICAL

39. Have you had menstrual periods that were painful?
40. Are you having trouble with the change of life?
41. Do you bleed when it is not your period?
42. Are your periods regular?
43. Do you have a discharge or itching in your vagina (privates)?
44. Do you have or have you had a lump in your breast?
45. Are you pregnant?

LOCOMOTOR

46. Do your joints often swell up and hurt?
47. Do you often have back pain?
48 Do you have a sharp pain in your back if you cough or sneeze?
49. Have you had a rash or itching of your skin anywhere?
50. Have you had a swelling or cyst at the bottom of your backbone?

PERSONAL LIFE

51. Do you take drugs or medicine to relax?
52. Have you often felt "keyed up" or "tense"?
53. Have you felt sad, weak or had the desire to cry?
54. Have you felt anxious or fearful?
55. Have you felt nervous or shaky inside?
56. Have you ever wished you were dead?
57. Do you have trouble concentrating or thinking?
58. Have you had sexual problems or difficulties?

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PERSONAL LIFE (continued)

Yes No

59. Do you <u>often</u> have problems remembering where you put things?
60. Do you worry a lot?
61. Do you dream often of frightening or bad circumstances?
62. Do you have frequent headaches?
63. Do you often wake up and lie awake for some time?
64. Do money matters cause you a great deal of worry?
65. Do you want to be alone much of the time?
66. Do you feel that meeting new people is very hard for you?
67. Do you strongly oppose participating in recreational or sports activities?
68. Have you avoided visiting your neighbors and/or friends?
69. Do you listen to the radio or TV or read the newspaper often?
70. Do you have problems at your job or at school?
71. Are you dissatisfied with your marriage at this time?
72. Do you feel sexually inadequate and/or unfulfilled?
73. Have you ever used cocaine, heroin, marijuana (pot), or LSD (acid, etc.)?
74. Have you seriously thought of ending your life?
75. Do you often hear sounds or voices when nobody is present?
76. Do you feel that people are often against you?
77. Would you like to have more power or influence?
78. Do you feel hopeless about the future?
79. Would you like an opportunity to discuss your problems with someone?

_____ _____

Signature of Person Completing this Form Date

_____

Relationship to Patient