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FORMS: Fill out prior to your appointment and bring with you. Call the office with any questions.

DATA BASE SHEET: SIDE 1 Today's Date_____/_____/_____

Name_____

Occupation_____

Hobbies_____ Primary Care Doctor_____

When was the last time you were in the hospital? _____

IN THE LAST YEAR HAVE YOU HAD (check YES or NO)

YES	NO	(1)
_____	_____	dizziness
_____	_____	fainting spells
_____	_____	headaches
_____	_____	convulsion (fit)
		(4)
_____	_____	nosebleeds
_____	_____	sinus/hay fever
_____	_____	nasal discharge
_____	_____	sore throats
_____	_____	trouble w/swallowing
_____	_____	much hoarseness
		(7)
_____	_____	stomach pain/cramps
_____	_____	much gas after eating
_____	_____	foods you can't eat
_____	_____	diarrhea/constipation
_____	_____	nausea or vomiting
_____	_____	rectal pain/bleeding
_____	_____	blood in stools
_____	_____	white or black stools
_____	_____	change in bowel habits
		(bowels move _____ times/day
		_____ times/week
		(10)
_____	_____	muscle ache
_____	_____	muscle cramps
_____	_____	joint pain/arthritis
_____	_____	joint stiffness
_____	_____	hot or cold hands/feet
_____	_____	Do you use laxatives?
_____	_____	Do you use alcohol?
_____	_____	Do you use tobacco?
How much sleep do you get at night?		
How much do you drink of:		
water_____ milk _____		

YES	NO	(2)
_____	_____	eye pain
_____	_____	vision problems
_____	_____	blurred vision
_____	_____	light bothers eyes
		(5)
_____	_____	chest pain
_____	_____	shortness of breath
_____	_____	heart palpitation
_____	_____	swollen ankles
_____	_____	night sweating
_____	_____	numb hand/foot
		(8)
_____	_____	urgent need to void
_____	_____	smoking colored urine
_____	_____	leaking of urine
_____	_____	pain/burn w/urination
_____	_____	kidney/bladder infect.
_____	_____	dribbling after urination
_____	_____	difficult start/stop stream
_____	_____	urine stream split/spray
_____	_____	frequent urination
		(daily or nightly)
		(11)
_____	_____	marked tiredness
_____	_____	recent weight change
_____	_____	frequent thirst
_____	_____	increased appetite
_____	_____	poor appetite
How often? _____		
How often? _____ How much?		
How often? _____ How much?		
_____ hours		
coffee_____ tea _____		

YES	NO	(3)
_____	_____	many earaches
_____	_____	ringing in ears
_____	_____	ear discharge
_____	_____	deafness
		(6)
_____	_____	coughing spells
_____	_____	asthma/emphysema
_____	_____	cough up blood
_____	_____	TB or pneumonia
_____	_____	many colds
_____	_____	pain w breathing
_____	_____	breast tender/sore
_____	_____	new breast lumps
_____	_____	nipple discharge
		(9)
_____	_____	depression
_____	_____	nervousness
_____	_____	insomnia
_____	_____	hands shake
_____	_____	skin itches

HAVE YOU HAD ANY SURGERY ON ANY OF THE FOLLOWING:

YES	NO	Year	
_____	_____	_____	legs or arms
_____	_____	_____	prostate
_____	_____	_____	appendix
_____	_____	_____	gallbladder
_____	_____	_____	tonsils
_____	_____	_____	tumor

YES	NO	Year	
_____	_____	_____	chest
_____	_____	_____	breast
_____	_____	_____	spine
_____	_____	_____	female organs
_____	_____	_____	cesarean section
_____	_____	_____	other surgeries

YES	NO	Year	
_____	_____	_____	back
_____	_____	_____	neck
_____	_____	_____	hernia
			(rupture)

List: _____
_____

Have you ever had broken or dislocated bones or bad cuts? _____

DATA BASE SHEET: SIDE 2

What medications are you currently taking? (list)

_____

_____

Vitamins or mineral supplements? (list)

_____

_____

Do you experience reactions to any DRUGS? (list)

_____

_____

PAST ILLNESSES

YES	NO	Year		YES	NO	Year	
_____	_____	_____	measles	_____	_____	_____	migraine headache
_____	_____	_____	mumps	_____	_____	_____	heart problems
_____	_____	_____	chicken pox	_____	_____	_____	kidney problems
_____	_____	_____	German measles	_____	_____	_____	epilepsy or convulsion
_____	_____	_____	polio	_____	_____	_____	blood or bleeding problems
_____	_____	_____	rheumatic fever	_____	_____	_____	venereal disease (V.D. or G.C.)
_____	_____	_____	scarlet fever	_____	_____	_____	diabetes (sugar)
_____	_____	_____	tuberculosis	_____	_____	_____	thyroid disease
_____	_____	_____	pneumonia	_____	_____	_____	blood transfusions or jaundice
_____	_____	_____	whooping cough	_____	_____	_____	high blood pressure
_____	_____	_____	ALLERGIES	_____	_____	_____	varicose veins

EXERCISE: How often (per day/week) Minutes

_____ _____ _____

_____ _____ _____

FAMILY HISTORY

	Living?	Age	State of Health	Deceased	Age	Cause of Death
Father	_____	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____	_____

Number of sisters _____ brothers_____ Illnesses? (who) _____

Have your grandparents, parents, uncles, aunts, brothers, sisters, or children ever been treated for any of the following:

YES	NO		Who?	YES	NO		Who
_____	_____	cancer	_____	_____	_____	Hardening of the arteries	_____
_____	_____	Diabetes	_____	_____	_____	Kidney Trouble	_____
_____	_____	Tuberculosis	_____	_____	_____	High blood Pressure	_____
_____	_____	Heart Disease	_____	_____	_____	Hay fever or asthma	_____
_____	_____	Nervous Breakdown	_____	_____	_____	Mental illness/problems	_____