

TO BE ANSWERED BY BOTH MEN AND WOMEN:

HAVE YOU . . . **Yes** **No**

Fainted recently?

Had spells of dizziness?

Had spells of weakness in an arm or leg?

Had ringing or roaring in ears?

Had recent numbness or tingling in arms, legs or face?

Ever had convulsions?

Had recent double vision?

Had recent trouble with memory, coordination, or speech?

Had recent or temporary loss of vision in one eye?

Had frequent or severe headaches?

 Do they cause visual trouble?

 Do they awaken you at night?

 Do they cause pain on one side of the head?

 Do they feel like a tight band?

 Do they pain mostly in back of head and neck?

 Does aspirin or Tylenol relieve them?

DO YOU HAVE SHORTNESS OF BREATH? **Yes** **No**

During your usual work

Does it awaken you at night?

While climbing a flight of stairs?

Is it accompanied by wheezing?

DO YOU . . . **Yes** **No**

Have a chronic cough?

Cough up much sputum?

Cough up blood?

Sleep on more than one pillow?

DO YOU HAVE CHEST DISCOMFORT? **Yes** **No**

When exerting yourself?

When walking up a hill?

After a heavy meal?

When upset or excited?

That awakens you from sleep?

That occurs only at rest?

That radiates to the neck or down the arm?

That disappears if you rest?

Associated with a thumping or racing heart?

That is worse if you lie flat?

DO YOU HAVE DIGESTIVE PROBLEMS?
IS THERE . . . **Yes** **No**

Pain 1-2 hours after eating?

Pain following fried, greasy foods?

Pain that awakens you at night?

Relief from antacids?

Relief with milk or eating?

Pain while eating or immediately after?

Relief with bowel movement?

Recent onset of vomiting?

Blood or dark brown material in the vomit?

Loss of appetite?

Difficult or painful swallowing?

Recent heartburn or indigestion?

HAVE YOU HAD A RECENT CHANGE IN BOWEL HABITS? **Yes** **No**

Crampy pain in abdomen?

Pain during or after bowel movement?

Ribbon-like stools?

Do you use strong laxatives or enemas?

Alternating diarrhea and constipation?

Blood in stool?

Black stools (like tar)?

HAVE YOU HAD URINARY PROBLEMS IN THE PAST 6 MONTHS?
IS THERE . . . **Yes** **No**

Burning with urination?

Dark colored urine?

Trouble holding the urine?

A history of kidney or bladder infections?

A history of kidney stones?

Blood in urine?

Trouble starting to urinate?

Frequent urination at night?

A change in urine stream - less strong?

QUESTIONS FOR WOMEN ONLY: **Yes** **No**

Are you still having regular monthly periods?

Cramps, backache, and/or irritability with periods?

Spotting between periods?

If you are through menopause, any recent spotting? ..

If you are through menopause, any hot flashes?

Date of last menstrual period's onset? _____

Date of previous period's onset? _____

How many days are your periods apart? _____

How long do they usually last? _____

How many pregnancies have you had? _____

How many children have you had? _____

Date of last pap smear? _____

Any *abnormal* pap smears in the past? _____

Do you do breast self-exams regularly? _____

Have you noticed any lumps recently? _____

Are you practicing birth control? _____

Type? _____

QUESTIONS FOR MEN ONLY: **Yes** **No**

Any loss of sexual activity?

 How long? _____

Discharge from penis?

Previous hernia (rupture)?

Prostate problems?

Swelling in scrotal sack?

WHY HAVE YOU COME TO THE DOCTOR AT THIS TIME?
