### Symptoms

**GENERAL**
- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

**MUSCLE/JOINT/BONE**
- Pain, weakness, numbness in:
  - Arms
  - Back
  - Feet
  - Hands
  - Hips
  - Legs
  - Neck
  - Shoulders

**GENITO-URINARY**
- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

**GASTROINTESTINAL**
- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

**CARDIOVASCULAR**
- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

**EYE, EAR, NOSE, THROAT**
- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - Flashes
- Vision - Halos

**SKIN**
- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

**MEN only**
- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

**WOMEN only**
- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

**Conditions**

**AIDS**
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts

**Chemical Dependency**
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes

**High Cholesterol**
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio

**Prostate Problem**
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

### Medications

List medications you are currently taking.

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Phone</th>
</tr>
</thead>
</table>

### Allergies - TO DRUGS


### Health History
<table>
<thead>
<tr>
<th>Relation</th>
<th>Age</th>
<th>State of Health</th>
<th>Age at Death</th>
<th>Cause of Death</th>
<th>Check (✓) if, your blood relatives had any of the following: Disease</th>
<th>Relationship to you</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Arthritis, Gout</td>
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<tr>
<td>Mother</td>
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<td>Asthma, Hay Fever</td>
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<tr>
<td>Brothers</td>
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<td>Cancer</td>
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<td>Chemical Dependency</td>
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<td>Diabetes</td>
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<td>Heart Disease, Strokes</td>
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<tr>
<td>Sisters</td>
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<td></td>
<td>High Blood Pressure</td>
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<td>Kidney Disease</td>
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<td>Tuberculosis</td>
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<td>Other</td>
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</tr>
</tbody>
</table>

**Hospitalizations / Surgery**

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital</th>
<th>Reason for Hospitalization and Outcome</th>
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<tbody>
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</tbody>
</table>

**Pregnancies**

<table>
<thead>
<tr>
<th>Year of Birth</th>
<th>Sex of Birth</th>
<th>Complications if any</th>
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</tbody>
</table>

**Health Habits**

Check (✓) which substances you use and describe how much you use.

- Caffeine
- Tobacco
- Drugs
- Other

**Alcohol Occupational**

Check (✓) if your work exposes you to the following:

- Stress
- Hazardous Substances
- Heavy Lifting
- Other

**Occupation**

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: ____________________________  Date: __________

Reviewed By: ____________________________  Date: __________