Name: _____ **Date:** _____

Please answer the following questions.

Any visual difficulty, double vision, eye pain or redness?	**Yes**	**No**
Difficulty hearing, painful or runny ears?	**Yes**	**No**
Any ringing or buzzing in ears?	**Yes**	**No**
Any trouble with sneezing, allergies, sinus infection or hoarse voice?	**Yes**	**No**
Any nosebleeds, frequent colds, sore throats or lump in the throat?	**Yes**	**No**
Problems with Gums, teeth or tongue?	**Yes**	**No**
Any headaches or migraines?	**Yes**	**No**
Trouble with chronic chest pain, cough, pleurisy, pneumonia or coughing blood?	**Yes**	**No**
Any soaking night sweats, chills, fever or hot flashes?	**Yes**	**No**
Any chronic chest condition, asthma, wheezes or tuberculosis (TB)?	**Yes**	**No**
Prior TB skin test or chest x-ray?	**Yes**	**No**
Ever lived with anyone with tuberculosis?	**Yes**	**No**
Ever had high blood pressure, angina, heart pain or heart attack?	**Yes**	**No**
Any shortness of breath, palpitations, fluttering, or heart murmurs?	**Yes**	**No**
Any leg cramps or ankle swelling?	**Yes**	**No**
Ever had rheumatic fever or other heart conditions?	**Yes**	**No**
Any upset stomach, heartburn, indigestion, or ulcers?	**Yes**	**No**
Any belching, bloating, vomiting, or appetite change?	**Yes**	**No**
Any sour or bitter taste in your mouth?	**Yes**	**No**
Any stomach or belly pain or weight loss?	**Yes**	**No**
Ever had bloody diarrhea, loose bowels, constipation, or black stools?	**Yes**	**No**
Any piles, hemorrhoids, or rectal pain?	**Yes**	**No**
Ever had jaundice, hepatitis or gallstones?	**Yes**	**No**
Ever had typhoid, intestinal parasites, colitis, or other intestinal trouble?	**Yes**	**No**
Ever had venereal disease such as gonorrhea, syphilis or herpes?	**Yes**	**No**
Any hernia, rupture or trouble with genital area?	**Yes**	**No**
Any difficulty starting your urinary stream or losing it too easily?	**Yes**	**No**
Any frequency, urgency, or pain while urinating?	**Yes**	**No**
Ever passed any blood r had cystitis, nephritis, or kidney stones?	**Yes**	**No**
How many times do you get up at night to urinate?	_____	
Any painful menstrual periods, vaginal discharge or bleeding between periods?	**Yes**	**No**
Ever been pregnant or had a miscarriage?	**Yes**	**No**
Date of last menstrual period?	_____	
(Men) Any prostate, testicle problems, or impotence?	**Yes**	**No**
Any dizziness, fainting, loss of balance, or loss of consciousness?	**Yes**	**No**
Do you have numbness or tingling, or muscle weakness?	**Yes**	**No**
Ever been paralyzed or had a stroke?	**Yes**	**No**
Any twitching or tic of the face, head or shoulders?	**Yes**	**No**
Ever unconscious or have a convulsion or seizure or fainting?	**Yes**	**No**
Any stammering, stuttering, inability to speak or get the correct word out?	**Yes**	**No**
Any bed-wetting, sleepwalking, or frightening dreams?	**Yes**	**No**
Ever had anemia, bruising, clotting or a bleeding problem?	**Yes**	**No**
Ever had malaria, diabetes, goiter or thyroid problems?	**Yes**	**No**
Ever had thyroid or facial x-rays?	**Yes**	**No**

Ever had a tumor, cancer, or abnormal Pap smear?……	**Yes**	**No**
Are you underweight or overweight?……	**Yes**	**No**
Do you sweat a lot, or have trouble with hot or cold weather?……	**Yes**	**No**
Any skin rashes, hair or nail problems?……	**Yes**	**No**
Trouble with rheumatism, arthritis, gout, joint pain or morning stiffness?……	**Yes**	**No**
Do you have a weak or painful feet or back?……	**Yes**	**No**
Are you often fatigued or exhausted or does regular work tire you out?……	**Yes**	**No**
Are you frequently ill or confined to bed?……	**Yes**	**No**
Do you worry about your health?……	**Yes**	**No**
Do you have difficulty in falling or staying asleep?……	**Yes**	**No**
Are you clumsy, tense or do you shake or tremble?……	**Yes**	**No**
Are you unhappy, fearful, depressed or tearful?……	**Yes**	**No**
Ever wished life were over and you were away from it all?……	**Yes**	**No**
Do you consider yourself a nervous person?……	**Yes**	**No**
Ever had a serious breakdown requiring hospitalization?……	**Yes**	**No**
Would you like to discuss marital or sexual difficulties, sexual preference or gender identity?……	**Yes**	**No**