DEFINED DATABASE

MEDICAL CARE CENTER
201 S. MILWAUKEE
LAKE VILLA, IL 60046

PREVENTIVE MEDICINE · INTERNAL MEDICINE · CARDIOLOGY

Patient's name_____

Birthdate_____ Age_____

Address_____ Zip_____

_____

Phone Number ( ) _____ Date_____

HISTORY

Cardiovascular:

		Check Yes or No for each question: NO	YES	WHEN
1.	Do you now have, or have you ever had pain or discomfort in the chest or arms? IF NO, SKIP TO QUESTION #18.	___	___	_____
2.	Is or was the pain or discomfort located:			
	(a) beneath the breast bone?	a___	___	_____
	(b) near the left nipple?	b___	___	_____
	(c) near the right nipple?	c___	___	_____
	(d) in the back:	d___	___	_____
	(e) some other place in the chest, if so, where?_____	e___	___	_____
	(f) in the left arm?	f___	___	_____
	(g) in the right arm?	g___	___	_____
	(h) in the left shoulder?	h___	___	_____
	(i) in the right shoulder?	i___	___	_____
	(j) in the left elbow?	j___	___	_____
	(k) in the right elbow?	k___	___	_____
	(l) in the left wrist?	l___	___	_____
	(m) in the right wrist?	m___	___	_____
	(n) other (specify):_____	n___	___	_____

	NO	YES	WHEN
3. Does or did the pain in the chest spread to the:			
(a) neck?	a___	___	_____
(b) jaw?	b___	___	_____
(c) teeth?	c___	___	_____
(d) left arm?	d___	___	_____
(e) right arm?	e___	___	_____
(f) both arms?	f___	___	_____
(g) left arm and neck?	g___	___	_____
(h) other (specify):_____	h___	___	_____
4. Is or was the pain produced by:			
(a) walking?	a___	___	_____
(b) climbing stairs?	b___	___	_____
(c) sexual intercourse?	c___	___	_____
(d) being upset?	d___	___	_____
(e) eating?	e___	___	_____
(f) eating and then walking?	f___	___	_____
(g) exposure to the cold?	g___	___	_____
(h) other (specify):_____	h___	___	_____
5. Does or did the pain wake you at night?	___	___	_____
6. Is or was the pain made worse by taking a deep breath?	___	___	_____
7. Is or was the pain made worse by twisting the upper part of the body?	___	___	_____
8. Is or was the pain made worse by moving the arms and shoulders?	___	___	_____
9. Does or did the pain or discomfort last:			
(a) one second or less?	a___	___	_____
(b) one minute or less?	b___	___	_____
(c) one to five minutes?	c___	___	_____
(d) five to ten minutes?	d___	___	_____
(e) ten to fifteen minutes?	e___	___	_____
(f) more than fifteen minutes?	f___	___	_____
(g) hours at a time?	g___	___	_____
(h) days at a time?	h___	___	_____
(i) longer?	i___	___	_____
10. Do or have you used nitroglycerin for the pain?	___	___	_____
11. Does or did the nitroglycerin relieve the pain or discomfort within:			
(a) one minute?	a___	___	_____
(b) thirty seconds?	b___	___	_____
(c) one to two minutes?	c___	___	_____
(d) five minutes?	d___	___	_____
(e) more than ten minutes?	e___	___	_____

		NO	YES	WHEN
12.	When did you first notice chest discomfort?			
13.	Assuming you first noticed the chest discomfort some time in the past, how long have you been free of discomfort?			
14.	How often do you have the chest discomfort now?			
15.	Has the chest discomfort changed in the last month? IF NO, SKIP TO QUESTION #16.	___	___	_____
	(a) are you having more attacks during the last month?	a___	___	_____
	(b) is less effort required to cause the discomfort?	b___	___	_____
	(c) does the discomfort wake you at night?	c___	___	_____
	(d) does the discomfort last longer than it did one month ago?	d___	___	_____
	(e) does nitroglycerin relieve you as quickly as it did a month ago?	e___	___	_____
16.	Are you now, or have you been short of breath? IF NO, SKIP TO QUESTION #24.	___	___	_____
17.	Does walking or climbing stairs make you short of breath?	___	___	_____
18.	Do you elevate your head with a pillow in order to breathe easier at night?	___	___	_____
19.	Have you been awakened from sleep with breathlessness or cough?	___	___	_____
20.	Is your shortness of breath increasing in frequency or severity?	___	___	_____
21.	Do you notice yourself breathing rapidly at times?	___	___	_____
	(a) do you develop numbness around the lips and in the fingers when you breathe rapidly?	___	___	_____
22.	Do you sigh often?	___	___	_____
23.	Do you notice wheezing when you breathe?	___	___	_____
24.	Do you cough more at night?	___	___	_____
25.	Have you ever coughed up blood?	___	___	_____

		NO	YES	WHEN
26.	Have you ever fainted?	___	___	_____
27.	Have you fainted or nearly fainted in the past year?	___	___	_____
28.	Are you conscious of your heartbeat?	___	___	_____
29.	Does your heart 'skip' beats?	___	___	_____
30.	Have you ever had a rapid heartbeat?	___	___	_____
	(a) was the rapid beat regular?	a___	___	_____
	(b) was the rapid beat irregular?	b___	___	_____
	(c) did the rapid beat start suddenly and stop suddenly?	c___	___	_____
31.	Have you noticed swelling of:			
	(a) both feet and both ankles?	a___	___	_____
	(b) right foot and lower right leg?	b___	___	_____
	(c) left foot and lower left leg?	c___	___	_____
32.	Have you noticed tenderness in:			
	(a) the right calf?	a___	___	_____
	(b) the left calf?	b___	___	_____
33.	Do you notice pain or tightness in your feet, calves, thighs or buttocks while walking?	___	___	_____
34.	Have you ever had painful whitening of your fingertips when you are cold?	___	___	_____
35.	Do you have or have you ever had an unexplained fever?	___	___	_____
36.	Have you ever had:			
	(a) rheumatic fever?	a___	___	_____
	(b) joint pain for which you were placed at bed rest?	b___	___	_____
	(c) a heart murmur?	c___	___	_____
	(d) angina pectoris or a heart attack?	d___	___	_____
	(e) pericarditis?	e___	___	_____
	(f) blood clot in the lungs?	f___	___	_____
	(g) phlebitis?	g___	___	_____
	(h) heart surgery?	h___	___	_____
	(i) varicose veins?	i___	___	_____
	(j) vein surgery?	j___	___	_____
	(k) artery surgery?	k___	___	_____
	(l) been in an automobile or other serious accident?	l___	___	_____
	(m) bacterial endocarditis?	m___	___	_____

	NO	YES	WHEN
(n) high blood pressure?	___	___	_____
(o) stroke?	___	___	_____
(p) high blood fat?	___	___	_____
(q) an electrocardiogram made?	___	___	_____
(r) a chest x-ray made?	___	___	_____
(s) cardiac catheterization?	___	___	_____
(t) an echocardiogram?	___	___	_____

37. Do you:

(a) participate in sports without a regular training program?	a___	___	_____
(b) have a regular exercise training program?	b___	___	_____
(c) fail to exercise at all or only rarely?	c___	___	_____
(d) smoke?	d___	___	_____
(e) drink 5 or more cups of coffee daily?	e___	___	_____
(f) drink more than 4 ounces of alcohol or wine each week?	f___	___	_____
(g) drink more than 2 cans of beer each week?	g___	___	_____
(h) have you gained weight since you were 21 years of age?	h___	___	_____
(i) do you consider yourself overweight?	i___	___	_____
(j) do you feel you are under pressure most of the time?	j___	___	_____
(k) do others feel you are overcritical of yourself or your work?	k___	___	_____
(l) do you have many 'deadlines' each day?	l___	___	_____
(m) do you get upset if you can't meet your deadlines?	m___	___	_____

38. Have you ever taken any of the following medications?

(a) Digitalis?	a___	___	_____
(b) Nitroglycerine?	b___	___	_____
(c) Quinidine?	c___	___	_____
(d) Pronestyl?	d___	___	_____
(e) Propranolol (Inderal)?	e___	___	_____
(f) pills or shots to eliminate fluid through the kidneys?(specify): _____	f___	___	_____
(g) blood pressure medications?(specify): _____	g___	___	_____
(h) blood thinning medications?(specify): _____	h___	___	_____
(i) other heart medications?(specify): _____	i___	___	_____

Endocrine:

		NO	YES	WHEN
39.	Do you consider yourself underweight?	___	___	_____
40.	Have you lost weight recently?	___	___	_____
41.	Is your appetite:			
	(a) poor?	a___	___	_____
	(b) the same as it has been?	b___	___	_____
	(c) excessive (more than usual)?	c___	___	_____
42.	Have you ever had:			
	(a) an overactive thyroid?	a___	___	_____
	(b) an underactive thyroid?	b___	___	_____
	(c) a thyroid operation?	c___	___	_____
	(d) radioactive drug treatment for your thyroid?(specify): _____	d___	___	_____
	(e) sugar diabetes?	e___	___	_____
	(f) other endocrine gland problems? (specify):_____ _____	f___	___	_____
43.	Have you taken:			
	(a) drugs to lose weight?	a___	___	_____
	(b) drugs to gain weight?	b___	___	_____
	(c) oral medication for diabetes?	c___	___	_____
	(d) insulin for diabetes?	d___	___	_____
	(e) corticosteroid?	e___	___	_____
	(f) thyroid pills?	f___	___	_____

Eye:

44.	Are you troubled with eye pain?	___	___	_____
45.	Have you ever had double vision?	___	___	_____
46.	Do you wear glasses?___contact lenses?___			
	(a) is your vision good with them?	a___	___	_____
47.	Do you use eye drops?	___	___	_____
48.	Do you have glaucoma?	___	___	_____
49.	Have you ever had retinal detachment?	___	___	_____
50.	Have you ever had loss of vision in one or both eyes?	___	___	_____

		NO	YES	WHEN
51.	Do you have cataracts?	___	___	___
52.	Have you ever had eye surgery?	___	___	___
53.	Do you have any other eye trouble?	___	___	___
	If yes, specify: _____			
54.	Has it been over a year since you have had your eyes examined?	___	___	___

Ear:

55.	Do you have trouble hearing?	___	___	___
56.	Do you wear a hearing aid?	___	___	___
57.	Do you have ringing or buzzing in your ears?	___	___	___
58.	Have you had vertigo or dizziness?	___	___	___
59.	Have you had an ear operation for deafness?	___	___	___
60.	Are you often exposed to loud noises?	___	___	___
61.	Do you use sharp objects to clean your ears?	___	___	___

Nose:

62.	Do you have nose bleeds?	___	___	___
63.	Do you have a nasal discharge?	___	___	___
64.	Do you have trouble breathing through your nose?	___	___	___
65.	Do you have or have you ever had bad sinus trouble?	___	___	___

Dental:

66.	Do you have bad teeth in need of repair?	___	___	___

	NO	YES	WHEN
67. Do you have difficulty eating because of trouble with teeth or gums?	___	___	_____
68. Do you bleed a long time after a tooth is extracted?	___	___	_____
69. Have all your teeth been removed?	___	___	_____
70. Do you have pyorrhea?	___	___	_____
71. Do you have any other dental problems?	___	___	_____

If yes, specify:_____
_____

72. Do you fail to go to the dentist at least once a year?	___	___	_____
73. Do you fail to brush your teeth at least once a day?	___	___	_____
74. Do you fail to use dental floss or tape?	___	___	_____

Mouth, Throat & Larynx:

75. Do you have sores or sorness on the lips or tongue?	___	___	_____
76. Do you have pain or difficulty in swallowing?	___	___	_____
77. Do you have hoarseness?	___	___	_____
78. Do you have a lump in your neck?	___	___	_____
79. Do you have a frequent sore throat with fever?	___	___	_____
80. Have you had an operation on your larynx?	___	___	_____
81. Have you had trouble with your salivary glands?	___	___	_____
82. Have you had other mouth, throat, or larynx problems?	___	___	_____

If yes, specify:_____
_____

Lungs:

		NO	YES	WHEN
83.	Do you have a cough?	___	___	_____
	If yes, for how long: _____			
84.	Do you cough up phlegm?	___	___	_____
	If yes: a. How often do you cough up phlegm _____ b. Has it ever been blood streaked _____			
85.	Have you coughed up blood?	___	___	_____
86.	Have you been short of breath?	___	___	_____
	(a) Does the shortness of breath interfere with your activities?	___	___	_____
87.	Have you ever had asthma?	___	___	_____
88.	Do you wheeze?	___	___	_____
89.	Have you been diagnosed as having lung disease?	___	___	_____
90.	Have you ever had pneumonia?	___	___	_____
91.	Have you ever had a blood clot go to your lungs?	___	___	_____
92.	Have you ever had a collapsed lung?	___	___	_____
93.	Have you ever had tuberculosis?	___	___	_____
94.	Have you been given drugs for the prevention or treatment of tuberculosis?	___	___	_____
95.	Have you ever had a positive skin test for tuberculosis?	___	___	_____
96.	Have you had an operation on your lungs?	___	___	_____
	If yes, specify: _____			
97.	Has it been more than a year since you have had a chest x-ray?	___	___	_____
98.	Do you have other known lung diseases?	___	___	_____
	If yes, specify: _____			

		NO	YES	WHEN
99.	Have you had repeated or prolonged exposure to:			
	(a) stone quarry dust?	a___	___	_____
	(b) coal mine dust?	b___	___	_____
	(c) asbestos?	c___	___	_____
	(d) moldy wheat?	d___	___	_____
	(e) beryllium? (element used as a hardening agent in alloys)	e___	___	_____
	(f) cotton mill dust?	f___	___	_____
	(g) metalworking?	g___	___	_____
	(h) other substances that irritate the lungs?	h___	___	_____
	Specify:_____			
100.	Do you smoke cigarettes?___cigar?___ pipe?___other? (specify):_____	___	___	_____
	(a) How much do you smoke daily?_____			
	(b) How long have you been smoking?_____			
101.	If you do not smoke now, have you ever smoked?	___	___	_____
	(a) When did you quit?_____			
	(b) How long did you smoke?_____			
102.	Do you take:			
	(a) Isuprel?	a___	___	_____
	(b) Aminophyllin?	b___	___	_____
	(c) antibiotics for lung infections?	c___	___	_____
	(d) other medications for your lungs?	d___	___	_____
	Specify:_____			

Gastrointestinal:

		NO	YES	WHEN
103.	Have you had abdominal pain?	___	___	_____
104.	Do you vomit often?	___	___	_____
105.	Have you ever vomited up dark brown material?	___	___	_____
106.	Have you ever vomited up blood?	___	___	_____
107.	Do you have indigestion, gas, heartburn, bloating, or sour stomach?	___	___	_____

		NO	YES	WHEN
108.	Are you constipated?	___	___	_____
109.	Do you take laxatives?	___	___	_____
110.	Do you have 2 or more loose stools daily?	___	___	_____
111.	Do you soil your underwear with bowel content?	___	___	_____
112.	Have you ever noticed black stools?	___	___	_____
113.	Have you ever noticed blood in your stools?	___	___	_____
114.	Have you ever had rectal itching, burning, or pain?	___	___	_____
115.	Have you ever lost your appetite?	___	___	_____
	Specify?_____			
116.	Have you ever had:			
	(a) typhoid fever?	a___	___	_____
	(b) stomach or duodenal ulcers?	b___	___	_____
	(c) a diagnosis of hiatus hernia?	c___	___	_____
	(d) jaundice?	d___	___	_____
	(e) hepatitis?	e___	___	_____
	(f) gallstones?	f___	___	_____
	(g) cirrhosis?	g___	___	_____
	(h) liver disease other than cirrhosis?	h___	___	_____
	(i) ulcerative colitis or regional enteritis?	i___	___	_____
	(j) diverticulosis?	j___	___	_____
	(k) pancreatitis?	k___	___	_____
	(l) peritonitis?	l___	___	_____
	(m) polyp or tumor in the bowel or rectum?	m___	___	_____
	(n) an inguinal hernia?	n___	___	_____
	(o) an inguinal hernia repaired?	o___	___	_____
	(p) appendectomy?	p___	___	_____
	(q) gallbladder surgery?	q___	___	_____
	(r) stomach surgery?	r___	___	_____
	(s) surgery on intestine?	s___	___	_____
	(t) hemorrhoids?	t___	___	_____
	(u) surgery for hemorrhoids?	u___	___	_____
	(v) other surgery on the rectum? Specify:_____	v___	___	_____
	(w) other gastrointestinal problems? Specify:_____	w___	___	_____
	(x) X-ray examination of your stomach or colon?	x___	___	_____
	(y) proctoscopic or sigmoidoscopic examination?	y___	___	_____

		NO	YES	WHEN
117.	Have you taken:			
	(a) Tums, Rolaids, Maalox, or other antacids?	a ___	___	_____
	(b) other medicines for your stomach or intestines? (specify):_____	b ___	___	_____

Genitourinary:

118.	Have you ever had an infection in the kidney or bladder?	___	___	_____
119.	Have you ever had painful burning when you urinated?	___	___	_____
120.	Has your urine every been dark or bloody?	___	___	_____
121.	Have you ever been injured in the kidney?	___	___	_____
122.	Have you ever had nephritis - acute or chronic inflammation of the kidney, caused by an infection (Bright's disease)?	___	___	_____
123.	Have you ever had tuberculosis of the kidney or bladder?	___	___	_____
124.	Have you ever had gonorrhea?	___	___	_____
125.	Have you ever had syphilis?	___	___	_____
126.	Have you ever had a kidney stone?	___	___	_____
127.	Have you ever had an operation on the kidney or bladder?	___	___	_____

Specify:_____

(for men):

128.	Have you ever had trouble starting to urinate?	___	___	_____
129.	Do you frequently have to get up at night to urinate?	___	___	_____

If yes, how often?_____

130.	Have you had the feeling you had not emptied your bladder after urinating?	___	___	_____

		NO	YES	WHEN
131.	Have you noticed a decrease in size of stream?	___	___	_____
132.	Have you had a discharge from your penis?	___	___	_____
133.	Have you been treated for prostate trouble?	___	___	_____
134.	Do you feel you are losing your sex drive?	___	___	_____
135.	Are you unable to sustain an erection?	___	___	_____
136.	Have you had a prostate operation?	___	___	_____
	Specify: _____			
137.	Have you had a tumor of the testicle?	___	___	_____
138.	Do you have a varicocele?	___	___	_____
139.	Have you been sterilized?	___	___	_____
140.	Do you take any form of sex hormone?	___	___	_____

(for women):

141.	Are you troubled by leaking urine?	___	___	_____
142.	Are you pregnant now?	___	___	_____
143.	Is inability to get pregnant a problem?	___	___	_____
144.	Have you ever had a tumor of the uterus, (womb)?	___	___	_____
145.	Have you ever had a pregnancy in your tubes?	___	___	_____
146.	Have you ever been immunized against or had a blood test for German measles?	___	___	_____
147.	Do you use birth control?	___	___	_____
	Specify: _____			
148.	Do you need advice regarding birth control?	___	___	_____
149.	Do you have a troublesome vaginal discharge?	___	___	_____
150.	Do you have a vaginal itch?	___	___	_____
151.	Is sexual intercourse painful?	___	___	_____

		NO	YES	WHEN
152.	Have you gone 6 months without a period?	___	___	_____
	IF YES, IS THIS BECAUSE:			
	(a) of menopause?	a___	___	_____
	(b) your menstrual period never started?	b___	___	_____
	(c) of an operation?	c___	___	_____
	(d) of pregnancy or nursing?	d___	___	_____
	(e) of other causes?	e___	___	_____
	Specify:_____			
153.	If you are no longer having periods, skip to question #159.			
154.	Do you have trouble with irregular periods?	___	___	_____
155.	Are you troubled by cramps or backache with your periods?	___	___	_____
156.	Do you have excess flow with periods?	___	___	_____
157.	Do you gain weight with a period?	___	___	_____
158.	Are you depressed with your period?	___	___	_____
159.	Give the following information:			
	(a) Date of last menstrual period:_____			
	(b) Days from beginning of one period to beginning of next:_____			
	(c) Number of pads/tampons used for each period:_____			
160.	Has vaginal bleeding reappeared after you thought periods had ceased?	___	___	_____
161.	Have you ever had infection in your tubes?	___	___	_____
162.	Have you ever had an operation on your tubes or ovaries?	___	___	_____
163.	Has your uterus been removed?	___	___	_____
164.	Have you ever had a D&C (dilatation and curettage)?	___	___	_____
165.	Havy you had other female operations?	___	___	_____
166.	Do you have other female problems?	___	___	_____
167.	Have you ever had an abnormal Pap smear?	___	___	_____
168.	How often do you get a Pap smear?_____	___	___	_____
169.	Have you noticed lumps or soreness in the breasts?	___	___	_____

		NO	YES	WHEN
170.	Have you had any trouble with your nipples?	___	___	_____
171.	Have you had x-ray examinations on your breasts (mammography)?	___	___	_____
172.	Do you need educational material regarding self breast examination?	___	___	_____
173.	Have your mother or sisters had breast cancer?	___	___	_____
174.	Do you take any medication for female problems?	___	___	_____
	Specify: _____			
175.	Do you go to a gynecologist?	___	___	_____

Hematology:

176.	Have you noticed prolonged bleeding from a cut?	___	___	_____
177.	Have you noticed easy bruising?	___	___	_____
178.	Have you noticed 'lumps' in your groin, armpits, or neck?	___	___	_____
179.	H ave you ever been anemic?	___	___	_____
180.	Do you take vitamin B_{12} or liver shots?	___	___	_____
181.	Have you ever taken iron for more than a month?	___	___	_____
182.	Have you ever had any blood disorder?	___	___	_____
	Specify: _____			
183.	Have you ever had (or do you now have):			
	(a) a bleeding disorder?	a___	___	_____
	(b) leukemia?	b___	___	_____
	(c) malaria?	c___	___	_____
	(d) sickle-cell disease?	d___	___	_____
	(e) blood destroyed by drugs?	e___	___	_____
	(f) surgical removal of the spleen?	f___	___	_____
	(g) operation (biopsy) of a lymph node?	g___	___	_____
	(h) radioactive material used to treat a blood disorder?	h___	___	_____
	(i) a blood transfusion?	i___	___	_____
184.	Have you had part of your stomach removed?	___	___	_____

	NO	YES	WHEN
185. Have you ever been exposed to excessive x-ray radiation?	___	___	_____

Specify: _____

Skin:

186. Have you had:

(a)	acne?	a___	___	_____
(b)	skin rash?	b___	___	_____
(c)	a mole or moles that changed in size or color?	c___	___	_____
(d)	itching of skin?	d___	___	_____
(e)	hives?	e___	___	_____
(f)	hemorrhogic area in the skin?	f___	___	_____
(g)	a skin cancer removed?	g___	___	_____
(h)	pilonidal sinus - ingrown hair in the sinus cavity?	h___	___	_____
(i)	psoriasis?	i___	___	_____
(j)	other skin problems?	j___	___	_____

Specify: _____

Musculoskeletal:

187.	Have you had back pain that interfered with your activities for 2 to 3 days?	___	___	_____
188.	Have you ever had joint stiffness, pain or swelling?	___	___	_____
189.	Have you noticed pain in the jaw joint?	___	___	_____
190.	Are you awakened from sleep frequently with leg cramps?	___	___	_____
191.	Are your muscles weak?	___	___	_____
192.	Do you wear an artificial limb?	___	___	_____
193.	Do you use a cane or crutch to walk?	___	___	_____

194. Have you ever had:

(a)	rheumatic fever?	a___	___	_____
(b)	arthritis of any type?	b___	___	_____
(c)	gout?	c___	___	_____
(d)	an operation on you back, neck, knees, or other joints?	d___	___	_____
(e)	'herniated disk?	e___	___	_____

		NO	YES	WHEN
195.	Do you take any of the following medications for joint pain?	___	___	_____
	(a) Aspirin?	a___	___	_____
	(b) Indocin - relieves pain, reduces fever, swelling & tenderness?	b___	___	_____
	(c) Colchicine - for treatment of gouty arthritis?	c___	___	_____
	(d) Allopurinol (Zyloprim) - for treatment of gout, recurrant uric acid formation, chronic joint pain?	d___	___	_____
	(e) Cortisone?	e___	___	_____
	(f) Gold injections?	f___	___	_____
	(g) Other medications for arthritis?	g___	___	_____
	Specify: _____			
196.	Do you have any other joint or muscle disease?	___	___	_____
	Specify: _____			

Neurologic System:

197.	Have you ever had severe recurring headaches?	___	___	_____
198.	Have you had dizzy spells or vertigo?	___	___	_____
199.	Have you had numbness or tingling hands or feet?	___	___	_____
200.	Have you lost your ability to speak for a few minutes?	___	___	_____
201.	Have you ever had trouble talking?	___	___	_____
202.	Have you had a 'black out' spell?	___	___	_____
203.	Have you suddenly lost track of things for a moment?	___	___	_____
204.	Have you had trouble with your memory?	___	___	_____
205.	Have you had trouble with coordination?	___	___	_____
206.	Have you noticed 'blindness' for a moment?	___	___	_____
207.	Have you ever had seizures?	___	___	_____
208.	Have you ever had a stroke?	___	___	_____
209.	Have you ever had paralysis?	___	___	_____

		NO	YES	WHEN
210.	Have you ever had a head injury?	___	___	_____
211.	Have you ever had a nerve or brain operation?	___	___	_____
	Specify: _____			
212.	Have you ever had any other nerve or brain disease?	___	___	_____
	Specify: _____			
213.	Have you had any other neurologic diseases?	___	___	_____
	Specify: _____			
214.	Do you take:			
	(a) Dilantin?	a___	___	_____
	(b) Phenobarbital?	b___	___	_____
	(c) medication for shaking?	c___	___	_____
	(d) Ergotamine?	d___	___	_____
	(e) medication for headaches?	e___	___	_____
	(f) other medication for a nervous system disease?	f___	___	_____
	Specify: _____			

Allergy:

215.	Are you allergic to any medication, or any other substance, food, etc.?	___	___	_____
	Specify: _____			
216.	From you experience, are you allergic to:			
	(a) wasp, bee, or other insect stings?	a___	___	_____
	(b) egg or egg products?	b___	___	_____
	(c) cosmetics, or hair dyes?	c___	___	_____
	(d) detergents, soaps, or shampoos?	d___	___	_____
217.	Have you consulted an allergist?	___	___	_____
218.	If you are allergic, do you fail to carry a card or identification tag stating your allergy?	___	___	_____

Immunizations:

219. Have you been immunized against:

			NO	YES	WHEN
(a)	tetanus?	a	___	___	_____
(b)	diphtheria?	b	___	___	_____
(c)	poliomyelitis?	c	___	___	_____
(d)	whooping cough?	d	___	___	_____
(e)	typhoid?	e	___	___	_____
(f)	smallpox?	f	___	___	_____
(g)	German measles?	g	___	___	_____
(h)	any other disease?	h	___	___	_____

Specify: _____

Infectious Diseases:

220. List the infectious diseases or serious infections you have had, and indicate the approximate date you had them:

			DATE
(a)	_____	a	_____
(b)	_____	b	_____
(c)	_____	c	_____
(d)	_____	d	_____
(e)	_____	e	_____
(f)	_____	f	_____
(g)	_____	g	_____
(h)	_____	h	_____

Family History:

221. Have any of your blood relatives had:

(a)	heart attack?	a	___	___	_____
(b)	high blood pressure?	b	___	___	_____
(c)	diabetes?	c	___	___	_____
(d)	rheumatic fever?	d	___	___	_____
(e)	high blood fat (cholesterol or triglycerides)?	e	___	___	_____
(f)	thyroid trouble?	f	___	___	_____
(g)	glaucoma before age 50?	g	___	___	_____
(h)	blindness before age 50?	h	___	___	_____
(i)	deafness before age 50?	i	___	___	_____
(j)	cystic fibrosis?	j	___	___	_____
(k)	cancer of the bowel?	k	___	___	_____
(l)	polyps of the bowel?	l	___	___	_____
(m)	cirrhosis?	m	___	___	_____
(n)	pernicious anemia?	n	___	___	_____
(o)	bleeding disorder?	o	___	___	_____

	NO	YES	WHEN
(p) sickle-cell disease?	p___	___	_____
(q) nervous system disease?	q___	___	_____
(r) alcoholism?	r___	___	_____
(s) psychiatric illness?	s___	___	_____
(t) durg abuse?	t___	___	_____

Life Problems:

222.	Are you 'nervous'?	___	___	_____
223.	Do you feel you are under pressure?	___	___	_____
224.	Do you sleep poorly?	___	___	_____
225.	Do you feel tired in the morning?	___	___	_____
226.	Do you sleep more now than you used to?	___	___	_____
227.	Do you feel depressed or 'blue'?	___	___	_____
228.	Do you feel lonely?	___	___	_____
229.	Do you have spells of crying?	___	___	_____
230.	Have you ever wished you were not alive?	___	___	_____
231.	Do you feel you will never get well?	___	___	_____
232.	Do you ever have a panic-stricken feeling?	___	___	_____
233.	Have you ever had a nervous breakdown?	___	___	_____
234.	Have you ever been treated by a psychiatrist?	___	___	_____
235.	Have you ever taken an overdose of pills?	___	___	_____
236.	Have you ever attempted suicide?	___	___	_____
237.	Do you take mood changing medications?	___	___	_____
238.	Do you feel you have an emotional problem?	___	___	_____
239.	Are you unhappy?	___	___	_____
240.	Do you feel you have too many responsibilities?	___	___	_____
241.	Do you feel dissatisfaction from most of the things you do?	___	___	_____

Medications:

242. Please list all the medications you are currently taking, and indicate the dosage:

		DOSAGE
(a)	_____	a_____
(b)	_____	b_____
(c)	_____	c_____
(d)	_____	d_____
(e)	_____	e_____
(f)	_____	f_____
(g)	_____	g_____
(h)	_____	h_____
(i)	_____	i_____

243. Please list all surgical procedures you have had and with approximate dates:

		DATE
(a)	_____	a_____
(b)	_____	b_____
(c)	_____	c_____
(d)	_____	d_____
(e)	_____	e_____

Patient Profile:

244. Please state your occupation:

_____

245. If you are retired or if you are not working, state your hobbies and special interests:

_____

_____

_____

246. Describe your usual day's activities and meals. Check 'yes' if anything about them should be a problem:

	NO	YES
Morning (breakfast): _____	___	___
(activities): _____	___	___
Afternoon (lunch): _____	___	___
(activities): _____	___	___
Evening (dinner): _____	___	___
(activities): _____	___	___
Snacks when: _____	___	___
what: _____		

	NO	YES	WHEN
247. Do you live:			
(a) alone?	a___	___	_____
(b) with parent(s)?	b___	___	_____
(c) with spouse?	c___	___	_____
(d) with friend(s)?	d___	___	_____
(e) with child (children)?Number_____	e___	___	_____
(f) with other relative(s)?	f___	___	_____
Specify:_____			
248. Are you:			
(a) single?	a___	___	_____
(b) married?	b___	___	_____
(c) remarried?	c___	___	_____
(d) divorced?	d___	___	_____
(e) separated?	e___	___	_____
(f) widowed?	f___	___	_____
249. Is your spouse ill?	___	___	_____
250. If you are married, are there problems?	___	___	_____
251. Do you have children?	___	___	_____
How many?_____			
252. Has there been an increase in arguments in your household?	___	___	_____
253. Do you have problems with finances?	___	___	_____
254. Are you retired?	___	___	_____
For how long?_____			
255. If you are not working but not retired, how long have you been unemployed?	_____		
256. Have you never worked regularly outside the home?	___	___	_____
257. If you are working, are you unhappy with your work?	___	___	_____
258. How many hours each week do you work?	_____		
259. How many weeks vacation do you take annually?	_____		
260. State the highest level you attained in school:_____			
261. Do you drink alcohol?	___	___	_____
(a) how much per week?_____			

		NO	YES	WHEN
(b)	find that your family objects to your drinking?	b___	___	_____
(c)	find that drinking interferes with your work?	c___	___	_____
(d)	consider drinking to be a problem?	d___	___	_____
(e)	Have you been admitted to a hospital because of drinking?	e___	___	_____
262.	Do you smoke?	___	___	_____
(a)	Do you feel you should stop?	___	___	_____
263.	Do you feel you are overworked?	___	___	_____
264.	Do you have too little time to eat your meals?	___	___	_____
265.	Do you need more leisure time?	___	___	_____
266.	Has there been any change in your sexual activity?	___	___	_____
267.	Have you avoided being safety-conscious?	___	___	_____
268.	Are you at a loss on how to give mouth to mouth resuscitation?	___	___	_____
269.	Are you at a loss regarding what to do at the scene of an accident?	___	___	_____
270.	Are you at a loss regarding what to do when a person faints?	___	___	_____
271.	Do you need additional information about accidental poisoning?	___	___	_____
272.	Would you like to have a copy of this questionnaire?	___	___	_____

Additional Comments