

WELLNESS/HEALTH PROFILE

Smoking History

Current Smoker
 Number of cigarettes per day _____
 Number of cigars per day _____
 Number of pipe bowls per day _____
 Total years you have smoked _____

Former Smoker
 Years since quitting _____
 Number of cigarettes per day _____
 Number of cigars per day _____
 Number of pipe bowls per day _____
 Total years you smoked _____

Alcohol Use

Don't Drink
 What is your average alcohol consumption (number) in a week? _____ Drinks
 (1 drink = 12 Oz. beer, 1 glass wine or 1.5 oz liquor)
 When do you drink alcohol?

Weekdays Weekends Both

Have you ever been criticized for your alcohol intake? Yes No
 Have you ever considered stopping drinking or drinking less? Yes No

Exercise

Occupation _____
 Do you exercise on a regular basis? Yes No Walking Running Non Weight bearing Other _____
 Do you do strength training? Yes No
 Do you take any supplements or steroids? Yes No

MEDICATIONS

Medication Allergies

Name of Medication	What Happens When You Take It?	When Did this occur?

List All Medications (include over the counter, herbs, etc) that you are currently taking.

Name of Drug (from the container)	What is it for?	Date Started	Prescribing Physician	Dosage	When do you take it

Do you use any of the following:

	Yes	No
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>
Other Street Drugs	<input type="checkbox"/>	<input type="checkbox"/>

Do you take any prescription drugs not prescribed for you? Yes No

IMMUNIZATIONS**HAVE YOU BEEN IMMUNIZED AGAINST:**

NAME OF VACCINE	LAST DOSE	DID YOU COMPLETE THE SERIES?
Hepatitis A		
Hepatitis B		
Pneumonia Vaccine		
Tetanus		
Diphtheria		
Pertussis (Whooping cough)		
Measles		
Mumps		
Rubella		
HIB		
Influenza (Flu)		

PREVIOUS SURGERY

What was done	When	Reason	Complications

PROCEDURE HISTORY

	WHEN	RESULT
LAST PHYSICAL EXAM		
LAST MAMMOGRAM		
LAST PAP SMEAR		
LAST COLONOSCOPY		
LAST PSA AND PROSTATE EXAM		
Other		
Other		

EXPOSURE HISTORY**Have you ever had Chemotherapy or Radiation Therapy** Yes No**LIST ALL MAJOR EXPOSURES TO CHEMICALS, ASBESTOS, TOXINS OR OTHER HAZARDS THAT CONCERN YOU.**

HAZARD	WHEN WAS THE EXPOSURE	FOR HOW LONG	KNOWN PROBLEMS

GENERAL MEDICAL QUESTIONS

	Yes	No
Any tumors, cysts, growths or Cancer (currently or in the past)?	<input type="checkbox"/>	<input type="checkbox"/>
Current or past eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Current problems with passing out?	<input type="checkbox"/>	<input type="checkbox"/>
Current problems with getting tired easily?	<input type="checkbox"/>	<input type="checkbox"/>

VASCULAR HISTORY

	Yes	No
Do you have any vascular (blood vessel) disease?	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged superficial veins, phlebitis, or blood clots?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Hardening of the arteries?	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure?	<input type="checkbox"/>	<input type="checkbox"/>
Stoke or Transient Ischemic Attack (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysms (Dilated arteries)?	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation or swelling of the hands or feet?	<input type="checkbox"/>	<input type="checkbox"/>
White fingers with cold temperatures?	<input type="checkbox"/>	<input type="checkbox"/>
Leg Cramps?	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>

PULMONARY HISTORY

	Yes	No
Do you have any respiratory (lung/airway) disease?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma (including exercise induced asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
(Do you use an inhaler?)	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
Acute or chronic lung infections?	<input type="checkbox"/>	<input type="checkbox"/>
Persistent or recurring coughing or wheezing?	<input type="checkbox"/>	<input type="checkbox"/>
Windpipe or lung surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Collapsed lung?	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath?	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis (curved spine) with breathing limitations?	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood?	<input type="checkbox"/>	<input type="checkbox"/>
History of Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
Previous positive TB skin test?	<input type="checkbox"/>	<input type="checkbox"/>

CARDIAC HISTORY

	Yes	No
Do you have any heart disease?	<input type="checkbox"/>	<input type="checkbox"/>

Heart pain or pressure in chest (Angina)?	<input type="checkbox"/>	<input type="checkbox"/>
Heart rhythm disturbance or palpitations (irregular beat)?	<input type="checkbox"/>	<input type="checkbox"/>
History of Heart Attack?	<input type="checkbox"/>	<input type="checkbox"/>
Organic heart disease (including prosthetic heart valves, mitral stenosis, heart block, heart murmur, mitral valve prolapse, pacemakers, Wolf Parkinson White (WPW) Syndrome, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
History of Rheumatic Fever?	<input type="checkbox"/>	<input type="checkbox"/>
Sudden loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____		

ENDOCRINE MEDICAL HISTORY

	Yes	No
Do you have any endocrine (hormone) disease?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (insulin requiring; units per day _____)? (Year of diagnosis _____)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (non-insulin requiring)? (Year of diagnosis _____)	<input type="checkbox"/>	<input type="checkbox"/>
Childhood Onset Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease?	<input type="checkbox"/>	<input type="checkbox"/>
Obesity?	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss or gain?	<input type="checkbox"/>	<input type="checkbox"/>

OBSTETRIC/GYN HISTORY

	Yes	No
Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Number of Pregnancies	<input type="checkbox"/>	<input type="checkbox"/>
Number of live births	<input type="checkbox"/>	<input type="checkbox"/>
Number of C-sections	<input type="checkbox"/>	<input type="checkbox"/>
Breast Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Breast Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Discharge from Nipples	<input type="checkbox"/>	<input type="checkbox"/>
Problems with Sex	<input type="checkbox"/>	<input type="checkbox"/>

MENTAL HEALTH HISTORY

	Yes	No
Do you have any psychiatric or mental health problems?	<input type="checkbox"/>	<input type="checkbox"/>
History of psychosis?	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric/psychological consultation?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty dealing with stress?	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks, hyperventilation, or anxiety or phobia disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Periods of uncontrollable rage?	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia?	<input type="checkbox"/>	<input type="checkbox"/>
Diagnosed depression, personality disorder, or neuroses?	<input type="checkbox"/>	<input type="checkbox"/>
History of Suicide attempts or plans	<input type="checkbox"/>	<input type="checkbox"/>

DERMATOLOGY/ALLERGY HISTORY

	Yes	No
Do you have any skin or allergy diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Sun sensitivity?	<input type="checkbox"/>	<input type="checkbox"/>
Allergic dermatitis to rubber or latex?	<input type="checkbox"/>	<input type="checkbox"/>
History of chronic dermatitis?	<input type="checkbox"/>	<input type="checkbox"/>
Active skin disease or infections?	<input type="checkbox"/>	<input type="checkbox"/>
Moles that have changed in size or color?	<input type="checkbox"/>	<input type="checkbox"/>
Allergies, including hay fever? (if so, to what?)	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULOSKELETAL HISTORY

	Yes	No
Do you have any muscle or bone disease?	<input type="checkbox"/>	<input type="checkbox"/>
Moderate to severe joint pain, arthritis, tendonitis or bursitis's?	<input type="checkbox"/>	<input type="checkbox"/>
Amputations?	<input type="checkbox"/>	<input type="checkbox"/>
Loss of use of arm, leg, fingers, or toes?	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sensation?	<input type="checkbox"/>	<input type="checkbox"/>
Loss of strength in hands, arms, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>
Loss of coordination?	<input type="checkbox"/>	<input type="checkbox"/>
Back injury?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic back pain? (back pain associated with neurological deficit or leg pain)	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Bone or joint deformity?	<input type="checkbox"/>	<input type="checkbox"/>
Any joints that dislocate easily?	<input type="checkbox"/>	<input type="checkbox"/>
Previous fractures or broken bones?	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGIC HISTORY

	Yes	No
Do you have any neurological disease?	<input type="checkbox"/>	<input type="checkbox"/>
Tremors, shakiness?	<input type="checkbox"/>	<input type="checkbox"/>
Seizures (recent or previous)?	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Cord Injury?	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling?	<input type="checkbox"/>	<input type="checkbox"/>
Head/spine surgery?	<input type="checkbox"/>	<input type="checkbox"/>
History of head trauma with persistent deficits?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic recurring headaches (migraine)?	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or fainting spells?	<input type="checkbox"/>	<input type="checkbox"/>
Brain tumor?	<input type="checkbox"/>	<input type="checkbox"/>
Loss of memory?	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia (difficulty sleeping)?	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL HISTORY

	Yes	No
Do you have any stomach or intestinal disease?	<input type="checkbox"/>	<input type="checkbox"/>
Hernias?	<input type="checkbox"/>	<input type="checkbox"/>
Colostomy?	<input type="checkbox"/>	<input type="checkbox"/>
Persistent stomach/abdominal pain or heartburn?	<input type="checkbox"/>	<input type="checkbox"/>
Active ulcer disease?	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, or other liver disease or a history of jaundice?	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight loss or weight gain?	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
Rectal disease, injury, or hemorrhoids?	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder problems?	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Incontinence?	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting blood or coffee ground material?	<input type="checkbox"/>	<input type="checkbox"/>

GENITOURINARY HISTORY

	Yes	No
Do you have any disease of the urinary system or genitals?	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent, difficult or painful urination?	<input type="checkbox"/>	<input type="checkbox"/>
History of sexually transmitted diseases (including HIV/AIDS)	<input type="checkbox"/>	<input type="checkbox"/>
Problems with incontinence?	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting after the age of 12 years?	<input type="checkbox"/>	<input type="checkbox"/>
Infertility (difficulty having children)?	<input type="checkbox"/>	<input type="checkbox"/>
Problems with sex?	<input type="checkbox"/>	<input type="checkbox"/>

VISION HISTORY

	Yes	No
Do you have any vision problems or eye disease?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision?	<input type="checkbox"/>	<input type="checkbox"/>
Loss of vision in either eye?	<input type="checkbox"/>	<input type="checkbox"/>
Eye irritation when using a respirator or goggles?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty reading?	<input type="checkbox"/>	<input type="checkbox"/>
Eye disease, glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
Eyeglasses?	<input type="checkbox"/>	<input type="checkbox"/>
Contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts?	<input type="checkbox"/>	<input type="checkbox"/>
Color blindness?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any type of eye surgery (e.g., radial keratotomy, PRK [laser],	<input type="checkbox"/>	<input type="checkbox"/>

cataract, etc.)? If "YES", please provide specific type and date of surgery: _____

EAR, NOSE, THROAT, HEARING AND SPEECH HISTORY

	Yes	No
Do you have any hearing problems or ear disease?	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to loud, constant noise or music in the last 14 hours?	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to loud, impact noise in past 14 hours?	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in the ears?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty hearing?	<input type="checkbox"/>	<input type="checkbox"/>
Ear infections or cold in the last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or balance problems?	<input type="checkbox"/>	<input type="checkbox"/>
Eardrum perforation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a hearing aide?	<input type="checkbox"/>	<input type="checkbox"/>
Are you in a Hearing Conservation Program?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had prior ear surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had recurrent sinus infections?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sinus or nasal allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had recurrent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
Do you stutter?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have severe gum or tooth problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hoarseness, difficulty swallowing, choking?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty speaking/talking?	<input type="checkbox"/>	<input type="checkbox"/>

OTHER PROBLEMS

PLEASE LIST ANY OTHER SYMPTOMS, PROBLEMS, OR MEDICAL HISTORY THAT YOU THINK WE NEED TO KNOW ABOUT.
