

NAME: _____

DATE: _____

- Do you have frequent, severe headaches _____ yes no
- Is your walking weak and unsteady _____ yes no
- Are you often dizzy and wobbly _____ yes no
- Do you have spells of unconsciousness (complete blackout) _____ yes no
- Is your eyesight blurred even when you wear glasses _____ yes no
- Do you suffer from eyestrain _____ yes no
- Is your eyesight rapidly getting worse _____ yes no
- Do you have times when you see double _____ yes no
- Do you have sudden short spells of blindness _____ yes no
- Are you hard of hearing _____ yes no
- Do you hear constant noises in your ears _____ yes no
- Do you have any drainage from your ears _____ yes no
- Do you have difficulty swallowing _____ yes no
- Do you suffer from many heavy chest colds _____ yes no
- Are you troubled with frequent coughing _____ yes no
- Do you cough up a lot of thick greenish sputum _____ yes no
- Do you sometimes cough up blood _____ yes no
- Do you ever have severe shortness of breath with your usual daily activity _____ yes no
- Do you sleep propped up high in bed to keep from getting short breath _____ yes no
- Do you have spells of weakness or paralysis of any part of your body _____ yes no
- Have you ever been told you have syphilis or "bad" blood or a positive serology _____ yes no
- Are you bothered by weakness or pain in one or both legs while walking _____ yes no
- Are both your ankles often swollen _____ yes no
- Do you ever have severe pain or pressure or a tight feeling in your chest _____ yes no
- Are you bothered by a sudden racing or fluttering of your heart _____ yes no
- Have you ever been told by a doctor that you had any abnormal EKG or heart tracing _____ yes no
- Do you ever vomit blood _____ yes no
- Do any particular foods make you sick _____ yes no
- Are you troubled with gas _____ yes no
- Have you ever been jaundiced _____ yes no
- Do you frequently have diarrhea _____ yes no
- Are you often constipated _____ yes no
- Do you have any abdominal pain _____ yes no
- Do you ever have bloody, tarry bowel movements _____ yes no
- Do you usually have to get up from sleep to urinate (pass water) _____ yes no
- During the day, do you have to urinate frequently _____ yes no
- Do you ever pass bloody or coffee-colored urine _____ yes no
- Do you have any pain on urination _____ yes no
- Do you have any difficulty starting or stopping your urine _____ yes no
- Do you lose any urine when you laugh, cough, or sneeze _____ yes no

FOR WOMEN ONLY

- Age at start of menstruation _____
- Number of days from the start of your period to the start of the next one _____
- Number of days you usually flow _____
- Have you ever been pregnant _____
- Number of pregnancies _____ Number of living children _____
- The first day of your last menstrual period _____
- Have you had a "PAP" test _____ When _____ Results _____
- If you have passed menopause (change of life), have you had any vaginal bleeding? _____
- Do you have bleeding when it is not your menstrual period? _____
- Have you noticed any lumps in your breasts? _____

HISTORY OF PREGNANCIES

YEAR	LENGTH OF LABOR	COMPLICATIONS	BIRTH WEIGHT	SEX

