

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELE: \_\_\_\_\_

**BELOW FOR DOCTOR USE ONLY**-----

**FOR PATIENTS USE:**

PLEASE CIRCLE THE SYMPTOMS LISTED BELOW AND ON THE BACK IF THEY HAVE BEEN A MAJOR OR MINOR PROBLEM IN THE PAST OR PRESENT, ALSO CIRCLE IF THEY HAVE NOT BEEN ANY PROBLEM. THIS SCREENING INFORMATION WILL HELP THE DOCTOR EVALUATE YOUR SITUATION. IF YOU DO NOT UNDERSTAND A WORD, PLEASE ASK THE DOCTOR.

**ALLERIGIC TO MEDICATIONS .... YES..... NO..... If YES, which ones** \_\_\_\_\_

What does it cause? \_\_\_\_\_

**OTHER ALLERGIES** \_\_\_\_\_

**MEDICATIONS CURRENTLY TAKING:** \_\_\_\_\_

**HOSPITALIZATIONS**                      **Approximate Age**                      **Where** \_\_\_\_\_

|                                |       |       |
|--------------------------------|-------|-------|
| Tonsillectomy                  | _____ | _____ |
| Appendectomy                   | _____ | _____ |
| Gallbladder Removal            | _____ | _____ |
| Womb Removal (Women Only)      | _____ | _____ |
| Hemorrhoid Surgery             | _____ | _____ |
| Hernia (Rupture fixed)         | _____ | _____ |
| Other Surgery..... YES .....NO | _____ | _____ |
|                                | _____ | _____ |
|                                | _____ | _____ |

**HABITS: DRINK:** Wine Whiskey Beer Coffee Tea Other \_\_\_\_\_

**SMOKE:** Cigarettes Cigars Other \_\_\_\_\_

How often? \_\_\_\_\_ How many per day? \_\_\_\_\_

**WHO LIVES AT HOME WITH YOU?** Alone Wife Husband Friend Other \_\_\_\_\_

How many children do you have? \_\_\_\_\_ How many living with you? \_\_\_\_\_

(Continued on reverse)

HOW MANY LIVING BROTHERS? \_\_\_\_\_ HOW MANY LIVING SISTERS? \_\_\_\_\_

HOW MANY DECEASED BROTHERS? \_\_\_\_\_ HOW MANY DECEASED SISTERS? \_\_\_\_\_

MOTHER Alive Deceased

FATHER Alive Deceased

WHAT KIND OF WORK DO YOU DO? \_\_\_\_\_

Circle if you have any problems with the following or circle NO if you have no problems.

1. Headaches Dizziness Ringing in ear NO Problems
2. Hearing Problems Ear Infections NO Problems
3. Runny Nose Sinus Problems Nose Bleeds Hay Fever NO Problems
4. Need Glasses See spots Double Vision NO Problems
5. Difficulty Chewing or swallowing foods NO Problems
6. Wear Dentures Sore Throats NO Problems
7. Recent Weight loss gain NO Problems
8. Vomiting Vomiting up blood Belly pain Ulcers NO Problems
9. Certain foods make you sick NO Problems
10. Yellow jaundice Gallbladder Problems NO Problems
11. Constipation Diarrhea Blood in bowel movements NO Problems
12. Shortness of Breath Chest Pain Asthma Wheezing NO Problems
13. Coughing frequently Coughing up blood Pneumonia Tuberculosis NO Problems
14. Heart Leakages Heart Murmur Heart Attack Abnormal Cardiograms Sit up at Night to Breathe Leg Swelling  
NO Problems
15. Diabetes High Blood Pressure Cholesterol Problems Gout NO Problems
16. Excessive Thirst Too Hot or too Cold Tired Sluggish NO Problems
17. Arthritis Joint Pain Muscle Cramps or aches NO Problems
18. Back Pain Pain in back of legs
19. Low Blood (anemia) Bleeding Tendencies NO Problems
20. Convulsions (Fits or Seizures) Dizzy Spells Tremors NO Problems
21. Psychiatric Consultation Strokes Weakness in one part of body or another NO Problems
22. Skin Rashes Boils NO Problems
23. Satisfied with life? YES NO Feel Depressed? YES NO

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**ALL WOMEN PLEASE COMPLETE BELOW ALL MALES MAKE SURE TO COMPLETE THE BPH QUESTIONNAIRE**

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1. REGULAR PERIODS? YES NO Last Menstrual Period? \_\_\_\_\_
2. NUMBER OF PREGNANCIES? \_\_\_\_\_
3. AGES OF CHILDREN? \_\_\_\_\_
4. DIFFICULTY WITH PREGNANCIES, LABOR, DELIVERY? YES NO
5. LAST PAP SMEAR? \_\_\_\_\_
6. ANY FEMALE PROBLEMS WITH OVARIES, UTERUS, OR VAGINA? \_\_\_\_\_
7. VAGINAL INFECTIONS OR VAGINAL DISCHARGE? \_\_\_\_\_

DOCTORS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_