THE WELLNESS GROUP

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FAMILY HISTORY: Do you or any family member have any of the following:

1. (Y) (N) Diabetes
2. (Y) (N) Tuberculosis
3. (Y) (N) Kidney Disease/Renal Disease
4. (Y) (N) Hypertension/Heart Disease
5. (Y) (N) Musculoskeletal Disease
6. (Y) (N) Back/Neck pain
7. (Y) (N) Cancer
8. (Y) (N) Other

GENERAL: Questions 9 to 57 pertain only to you

9. (Y) (N) Have You had Any Weight Changes In The Past Year
10. (Y) (N) Do You Have Any Allergies

E.N.T.

11. (Y) (N) Eye/Visual Dysfunction
12. (Y) (N) Ear/Deafness
13. (Y) (N) Tinnitus/Ringing In The Ears
14. (Y) (N) Epistaxis/Bloody Nose
15. (Y) (N) Sinusitis/Sinus Problems
16. (Y) (N) Tonsillectomy/Tonsillitis

GASTROINTESTINAL SYSTEM

17. (Y) (N) Nausea/Vomiting
18. (Y) (N) Peptic Ulcer Disease
19. (Y) (N) Dysphasia/Difficult Swallowing
20. (Y) (N) Indigestion/Heartburn
21. (Y) (N) Abdominal Pain/Swelling
22. (Y) (N) Diarrhea
23. (Y) (N) Constipation
24. (Y) (N) Gallbladder Disease
25. (Y) (N) Liver Disease
26. (Y) (N) Alcohol Intake _____ Light_____Moderate _____Heavy

PULMONARY SYSTEM

27. (Y) (N) Dyspnea/Trouble Breathing
28. (Y) (N) Cough/Sputum Production
29. (Y) (N) Tuberculosis
30. (Y) (N) Respiratory Infections
31. (Y) (N) Do You Smoke Presently _____Yes _____ No
32. (Y) (N) Have you Smoked In The Past _____ Yes _____ NO
    How Many Packs Per Day _____ For How Many Years _____

CARDIOVASCULAR SYSTEM

33. (Y) (N) Orthopnea/Paroxysmal Nocturnal Dyspnea/Shortness Of Breath
34. (Y) (N) Chest Pains
35. (Y) (N) Claudication/Leg Pain/Cramping After Walking
36. (Y) (N) Hypertension
37. (Y) (N) Rheumatic Fever

GENITOURINARY SYSTEM

38. (Y) (N) Increased Urinary Frequency/Urgency
39. (Y) (N) Painful Urination or Urination At Night
40. (Y) (N) Urinary Incontinence

FEMALES

41. (Y) (N) Menarche/Age Of First Menstrual Period _____
42. (Y) (N) Menopause _____
43. (Y) (N) Menstrual Flow Amount _____Duration_____ Interval _____
44. (Y) (N) First Day Of Last Cycle _____
45. (Y) (N) Date Of Last Pap _____
46. (Y) (N) Breast Lump/Pain/Discharge

ORTHOPAEDIC-NEUROLOGICAL SYSTEM

47. (Y) (N) Headaches
48. (Y) (N) Seizures
49. (Y) (N) Dizziness
50. (Y) (N) Insomnia Average Hours Sleep Per Night _____
51. (Y) (N) Weakness
52. (Y) (N) Nervousness
53. (Y) (N) Depression/Anxiety
54. (Y) (N) Head Injury
55. (Y) (N) Stroke
56. (Y) (N) Fractures/Dislocations/Sprains
57. (Y) (N) Low Back Pain/Neck Pain

CURRENT MEDICATIONS YOU ARE TAKING

_____

_____

HOSPITALIZATION HISTORY

_____

_____

FAMILY OR PRIMARY DOCTOR'S NAME & ADDRESS

_____