

PATIENT NAME: _____ **FAMILY HEALTH HISTORY**

Your Father		AGE	SIGNIFICANT HEALTH PROBLEMS	Your Mother		AGE	SIGNIFICANT HEALTH PROBLEMS
Your Sibling	<input type="checkbox"/> M			Your Children	<input type="checkbox"/> M		
	<input type="checkbox"/> F				<input type="checkbox"/> F		
	<input type="checkbox"/> M				<input type="checkbox"/> M		
	<input type="checkbox"/> F				<input type="checkbox"/> F		
	<input type="checkbox"/> M				<input type="checkbox"/> M		
	<input type="checkbox"/> F				<input type="checkbox"/> F		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Date of last menstruation:		
Period every _____ days		
Number of pregnancies _____ Number of live births _____		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEN ONLY

Do you usually get up to urinate during the night?	If yes, # of times _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel pain or burning with urination?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.			
<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Throat	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Bowel	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Lungs	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Circulation	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Other pain/discomfort:			