Smoking Status (circle one): Current every day smoker Current some day smoker Former smoker
Never smoked Smokeless tobacco user

_____

Do you drink alcohol?_____ If so, about how many drinks per day and for how many years?_____

Do you have a serious illness or injury?_____ If so, describe._____

What surgical procedures have you had? Date? Anesthetics?_____

_____

Screening tests (check any that you've had recently):

___ blood pressure checks
___ bone density
___ chest x-ray
___ cholesterol level
___ colonoscopy
___ diabetic HgbA1c test
___ digital rectal exam
___ EKG
___ flexible sigmoidoscopy
___ hearing exam
___ lead level test
___ lipid test
___ mammogram
___ occult stool test
___ PAP smear
___ PSA test
___ eye exam
___ other:

Review of Systems (circle yes or no and underline symptoms that apply)

1.	Do you have chills, fatigue, fever, or insomnia?	Yes	No
2.	Do you have loss of appetite or night sweats?	Yes	No
3.	Do you wear glasses or contacts or have any notable eye problems?	Yes	No
4.	Do you wear hearing aids or have any notable ear problems?	Yes	No
5.	Do you have chest pain, shortness of breath, or heart murmur?	Yes	No
6.	Do you have high blood pressure, heart racing, or varicose veins?	Yes	No
7.	Do you have asthma, bronchitis, or pneumonia?	Yes	No
8.	Do you have abdominal pain, constipation, or diarrhea?	Yes	No
9.	Do you have indigestion, nausea, or vomiting blood?	Yes	No
10.	Do you have difficulty or burning with urination or incontinence?	Yes	No
11.	Do you have problems with your neck, back, joints, or muscles?	Yes	No
12.	Do you have problems with your skin, hair, or nails?	Yes	No
13.	Do you have headaches, numbness, paralysis, or seizures?	Yes	No
14.	Do you have tingling, dizziness, or weakness?	Yes	No
15.	Do you have anxiety, depression, mood swings, or nervousness?	Yes	No
16.	Do you have dementia, paranoia, or memory loss?	Yes	No
17.	Do you have diabetes, hot flashes, or thyroid problems?	Yes	No
18.	Do you bruise easily or have a history of anemia?	Yes	No
19.	Do you have fever or seasonal allergies?	Yes	No
20.	Do you have persistent infections or exposure to HIV?	Yes	No

Please explain any "Yes" answers:_____

_____

_____

_____