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Last name, First, Middle			Date of Birth	Sex M F	Marital Status M D S W
Street Address			Ethnicity: Caucasian/African-American/Asian/Hispanic/ Native-American/East-Indian/Filipino/Other ( <b>circle one</b> )		
City	State	Zip code	Home Phone		Cell Phone
Employers Name			Work Phone		E-mail Address
Employer's Street Address			Social Security Number		Drivers License# & State
City	State	Zip code	Occupation		
Emergency Contact:		Relationship	Work Phone		
Street Address, City, State, ZIP			Home Phone		Cell Phone

**INSURANCE INFORMATION:**

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID number	Policy or ID number
Subscribers Name	Subscribers Name
Relationship to Patient	Relationship to Patient
Subscriber's Employer, Address, Telephone Number	Subscriber's Employer, Address, Telephone Number

**How did you hear about us?**    TV    Radio    Newspaper/Magazine    Seminar  
Doctor (Name: \_\_\_\_\_)    Friend/Family (Name: \_\_\_\_\_)  
Internet (Website: \_\_\_\_\_)    Other (Please Specify: \_\_\_\_\_)

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted to be as valid as the original.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT HISTORY QUESTIONNAIRE**

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. Please be thorough. Blue or black ink only, please.

AGE \_\_\_\_\_

DATE \_\_\_\_\_

GENDER \_\_\_\_\_

PRESENT WEIGHT	HEIGHT	BMI	DESIRED WEIGHT

**WEIGHT HISTORY/EVALUATION**

Please estimate as closely as possible for all that applies.

Life Event	Age	Weight
Birth weight		
Start of High School		
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		

***Pregnancy related Weight History (female patients only):***

Pregnancy #1            Year \_\_\_\_\_ Weight at start \_\_\_\_\_ at delivery \_\_\_\_\_

Pregnancy #2            Year \_\_\_\_\_ Weight at start \_\_\_\_\_ at delivery \_\_\_\_\_

Pregnancy #3            Year \_\_\_\_\_ Weight at start \_\_\_\_\_ at delivery \_\_\_\_\_

Pregnancy #4            Year \_\_\_\_\_ Weight at start \_\_\_\_\_ at delivery \_\_\_\_\_

**DIETARY HISTORY/EVALUATION**

Approximate age when you first seriously dieted: \_\_\_\_\_

*List the diets and diet programs you have tried:*

<b>Program</b>		<b>Dates</b>	<b>Duration</b>	<b>MD Supervised?</b>	<b>Max Loss</b>
Jenny Craig:	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Nutri-Systems	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Weight Watchers	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
OptiFast	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Medi Fast	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Fen/Phen/Redux	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Meridia	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Lindora	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
T.O.P.S.	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
O.A.	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Acupuncture	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Metabolife	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Atkins Diet	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Pritikin Diet	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____

List any physician-supervised and documented weight loss attempt: \_\_\_\_\_  
 \_\_\_\_\_

List any other diets and/or weight loss methods you've tried: \_\_\_\_\_  
 \_\_\_\_\_

**FOOD PREFERENCES**

*Indicate which foods you prefer (which foods would most likely make you go off a diet).*

Rank each selection from 1– like very much to 4– don't care.

- |                        |                    |                       |
|------------------------|--------------------|-----------------------|
| _____ Soda/Soft drinks | _____ French fries | _____ Chips/snacks    |
| _____ Steaks/chops     | _____ Candy        | _____ Potatoes        |
| _____ Chocolate        | _____ Pasta        | _____ Cookies         |
| _____ Pizza            | _____ Cakes/pies   | _____ Salad dressings |
| _____ Fried foods      |                    |                       |

**CO-MORBIDITIES: Have you had, or do you have, any of the following illnesses or symptoms?**

(\*\*Some of these questions may be redundant, however please complete to the best of your ability\*\*)

**1. High Blood Pressure:** Yes  No

If Yes: ♦ Year Diagnosed \_\_\_\_\_

♦ List medications \_\_\_\_\_

- No history of HTN
- Borderline, No Meds
- Diagnosis of HTN, no Meds
- Treatment with single med
- Treatment with multiple meds
- Poorly controlled by meds, organ Damage

**2. Congestive Heart Failure:** Yes  No

If Yes: ♦ Year Diagnosed: \_\_\_\_\_

- No Hx or s/s of CHF
- Class I: s/s with more than ordinary activity
- Class II: s/s with ordinary activity
- Class III: s/s with minimal activity
- Class IV: s/s @ rest

**3. Ischemic Heart Disease :** Yes  No

*Do you have, or have you had:*

- Angina
- M.I. (myocardial infarction, “heart attack”)
- CABG (coronary artery bypass graft)
- Abnormal EKG
- Stress test to rule out cardiac problems
- Palpitations
- ♦ List medications \_\_\_\_\_

- No Hx of ischemic heart disease
- Abnormal ECG, no active Ischemia
- History of MI or Anti-ischemic Meds
- PCI, CABG
- Active Ischemia

**4. Angina Assessment :**

- Chest pain Yes  No
- Chest pain with exercise Yes  No
- Chest pain at rest Yes  No
- M.I. (myocardial infarction, “heart attack”) Yes  No

- No chest pain s/s or Angina
- Anginal chest pain on with extreme exertion (running/swimming)
- Anginal chest pain with moderate activity/exertion
- Anginal chest pain with minimal exertion (walking across The room or “at rest”
- Unstable Angina
- Previous MI by Hx or by current w/u (wall motion abnormality)

**5. Peripheral Vascular Disease :** Yes  No

*Do you have, or have you had:*

- Pain in your lower legs
- Pain in your lower legs with walking

- No s/s of PVD
- Asymptomatic with Bruit
- Claudication, Anti-ischemic meds
- Transient ischemic attack, Rest Pain
- Procedure for PVD
- Stroke, loss of tissue secondary to Ischemia

Pain in your lower legs while asleep

**6. Lower Extremity Edema (Swelling):** Yes  No

If Yes: ♦ Do you have Edema (Swelling)? Yes  No

♦ Scaly & Thick Skin? Yes  No

♦ Leg Ulcers? Yes  No

Medications/Treatment \_\_\_\_\_

No s/s of lower extremity edema  
 Intermittent LE edema, not requiring treatment  
 S/S requiring treatment (diuretics, elevation, hose)  
 stasis ulcers  
 Disability, decreased function, hospitalization

**7. Deep Venous Thrombosis / Pulmonary Embolism:** Yes  No

No history of DVT/PE  
 History of DVT resolved with anticoagulation  
 Recurrent DVT with long term anticoagulation meds  
 Previous PE  
 Recurrent PE, decreased function, hospitalization  
 Vena Caval filter

**8. Glucose Metabolism (Diabetes Type II):** Yes  No

If Yes: ♦ Year Diagnosed: \_\_\_\_\_

• Gestational: Yes  No

• Neuropathy: Yes  No

• Retinopathy Yes  No

• Renal failure Yes  No

• Blindness Yes  No

♦ Controlled with:  Diet

Oral Medication (list) \_\_\_\_\_

♦ Last fasting blood sugar: \_\_\_\_\_

No s/s or evidence of Diabetes  
 Elevated fasting glucose  
 Diabetes, controlled with oral meds  
 Diabetes, controlled with insulin  
 Diabetes, controlled with Insulin and oral meds  
 Diabetes, with severe complications  
(Retinopathy, neuropathy, renal failure, blindness)

**9. Lipids (Dyslipidemia/Hyperlipidemia):** Yes  No

High Cholesterol: Yes  No

High Triglycerides: Yes  No

If Yes: ♦ Year Diagnosed \_\_\_\_\_

♦ List medications: \_\_\_\_\_

Not present  
 Present, no treatment required  
 Controlled with lifestyle change, including step1/step2 diet  
 Controlled with single medication  
 Controlled with multiple medications  
 Not controlled

**10. Gout (Hyperuricemia):** Yes  No

If Yes: ♦ Gouty Arthritis? Yes  No

Medications? \_\_\_\_\_

No s/s of gout/hyperuricemia  
 Hyperuricemia, no s/s  
 Hyperuricemia, medications  
 Arthropathy  
 Destructive joints  
 Disability, unable to walk



**14. Asthma:** Yes  No

If Yes: ♦ Year Diagnosed: \_\_\_\_\_

♦ ER visits/last 2 yrs: \_\_\_\_\_

♦ Hospitalizations last 2 years: \_\_\_\_\_

♦ Steroids last 2 years: Yes  No

♦ List medications \_\_\_\_\_

\_\_ No s/s of Asthma  
\_\_ Intermittent mild s/s, no meds  
\_\_ s/s controlled with oral inhaler (such as albuterol)  
\_\_ well controlled with ongoing daily meds  
\_\_ s/s not well controlled, steroids or anticholinergics  
\_\_ hospitalized within the last 2 years, history of intubation

**Shortness of breath (Dyspnea on Exertion) :** Yes  No

If Yes, : ♦ Can walk \_\_\_\_\_ blocks

♦ Stairs: \_\_\_\_\_ flight

**15. Gastro-Esophageal Reflux Disease:** Yes  No

(Heartburn/esophagitis/hiatus hernia)? Yes  No

If Yes: ♦ Year Diagnosed: \_\_\_\_\_

♦ Upper GI series? Yes  No

♦ Endoscopy? Yes  No

♦ Medications: \_\_\_\_\_

♦ Frequency of use: \_\_\_\_\_

Belching up acid or sour fluid. Yes  No

Coughing or choking at night? Yes  No

\_\_ No hx of GERD  
\_\_ Intermittent/variable symptoms, no meds  
\_\_ Intermittent medication  
\_\_ H2 blockers/low dose PPI  
\_\_ High dose PPI  
\_\_ Meet criteria for Antireflux surgery/Prior surgery for GERD

**16. Cholelithiasis:** Yes  No

If Yes: How was it Diagnosed?

Ultrasound

Physical Exam

Did you already have surgery? Yes  No

Emergently or electively

Do you still have problems? Yes  No

\_\_ No history of gallstones  
\_\_ Gallstones with no s/s  
\_\_ Gallstones with intermittent s/s  
\_\_ Gallstones with severe s/s or h/o cholecystectomy  
\_\_ Gallstones with complications requiring immediate surgery prior to Gastric Bypass  
\_\_ h/o cholecystectomy with ongoing complications not resolved

**17. Liver disease:** Yes  No

\_\_ No history of liver disease  
\_\_ Hepatomegaly modest, normal LFT's, Fatty change Category 1  
\_\_ Modest or greater hepatomegaly, LFT alteration, Category 2  
\_\_ Moderate to marked hepatomegaly, Category 3,  
Mild inflammation/mild fibrosis  
\_\_ Definite NASH, cirrhosis, Hepatic Dysfunction by LFT's  
\_\_ Hepatic Failure, Transplant indicated or done

**18. Back Pain:** Yes  No

- If Yes: ♦ Seen by Chiropractor? Yes  No
- ♦ Orthopedic Surgeon? Yes  No
- ♦ Seen by Family Doctor? Yes  No

Medications taken: \_\_\_\_\_

\_\_\_\_\_

- \_\_ No s/s of back pain
- \_\_ S/S requiring non-narcotic treatment
- \_\_ Degenerative changes/positive objective findings, s/s requiring narcotic treatment
- \_\_ Surgical intervention done or recommended pending Weight loss
- \_\_ Failed previous surgical intervention with existing s/s

**19. Musculoskeletal Disease:** Yes  No

- If Yes: ♦ Seen by Chiropractor? Yes  No
- ♦ Orthopedic Surgeon? Yes  No
- ♦ Seen by Family Doctor? Yes  No

- Pain in: Back? Yes  No
- Hips? Yes  No  (Right/Left/Both)
- Knees? Yes  No  (Right/Left/Both)
- Ankles? Yes  No  (Right/Left/Both)
- Feet? Yes  No  (Right/Left/Both)

♦ Medications taken: \_\_\_\_\_

- \_\_ No s/s of musculoskeletal dz
- \_\_ Pain with community ambulation
- \_\_ Non-narcotic analgesia required
- \_\_ Pain with household ambulation
- \_\_ Surgical intervention required (Arthroscopy)
- \_\_ Awaiting or past joint replacement or other disability

**20. Fibromyalgia :** Yes  No

If Yes, Specify Treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- \_\_ No hx of Fibromyalgia
- \_\_ Treatment with exercise
- \_\_ Treatment with non-narcotic meds
- \_\_ Treatment with narcotics
- \_\_ Treatment with narcotics: Surgical intervention done or recommended
- \_\_ Disabling, treatment not effective

**21. Polycystic Ovarian Syndrome :** Yes  No

- Menstrual irregularities Yes  No
- Excess Body hair Yes  No
- Infertility Yes  No

Medications: \_\_\_\_\_

\_\_\_\_\_

- \_\_ No hx of PCOS
- \_\_ s/s of PCOS, no treatment
- \_\_ OCP's or Anti-androgen Rx
- \_\_ Metformin or TZD
- \_\_ combination therapy
- \_\_ Infertility

**22. Menstrual Irregularities:** Yes  No

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- \_\_ No hx of menstrual irregularities
- \_\_ Irregular periods/oligomenorrhea
- \_\_ Menorrhagia
- \_\_ Amenorrhea
- \_\_ Prior total abdominal hysterectomy

Are your periods irregular? Yes  No

Have you had a Hysterectomy? Yes  No

**23. Psychosocial Impairment :** Yes  No

- No impairment
- Mild impairment in psychosocial functioning but able to perform all primary tasks
- Moderate impairment in psychosocial functioning but able to perform most primary tasks
- Moderate impairment in psychosocial functioning and unable to perform primary tasks
- Severe impairment in psychosocial functioning and unable to perform most primary tasks
- Severe impairment in psychosocial and unable to function

**24. Confirmed Mental Health Diagnosis:** Yes  No

- None
- Bipolar disorder
- Anxiety/panic disorder
- Personality disorder
- Psychosis

**Anxiety disorder?** Yes  No

If Yes: ♦ Year Diagnosed: \_\_\_\_\_

Have you been treated : Yes  No

If Yes: type of treatment:  Counseling  
 Hospitalization

♦ Medications taken: \_\_\_\_\_

**Panic disorder?** Yes  No

If Yes: ♦ Year Diagnosed: \_\_\_\_\_

Have you been treated Yes  No

If Yes: type of treatment:  Counseling  
 Hospitalization

♦ Medications taken: \_\_\_\_\_

**Bipolar disorder?** Yes  No

If Yes: ♦ Year Diagnosed: \_\_\_\_\_

Have you been treated Yes  No

If Yes: type of treatment:  Counseling  
 Hospitalization

♦ Medications taken: \_\_\_\_\_

**Personality disorder?** Yes  No

If Yes: ♦ Year Diagnosed: \_\_\_\_\_

Have you been treated? Yes  No

If Yes: type of treatment:  Counseling  
 Hospitalization

♦ Medications taken: \_\_\_\_\_



**30. Pseudotumor Cerebri (HEADACHES):** Yes  No

Do you experience Headaches? Yes  No

Do you experience any associated symptoms? Yes  No

If Yes, What are your symptoms? \_\_\_\_\_

Were any studies done to evaluate? Yes  No

Was an MRI done? Yes  No

Treatment/Medications? \_\_\_\_\_

No s/s

Headaches with dizziness, nausea, and/or controlled with diuretics.

Headaches with visual s/s and/or controlled with diuretics

Patient has had MRI to confirm PTC, is well controlled oral diuretics.

Patient is well controlled with stronger medications

Patient requires narcotics or has had (or needs) surgical intervention.

**31. Abdominal Hernia:** Yes  No

Date of diagnosis? \_\_\_\_\_

Have you had surgical repair? Yes  No

Has your hernia come back? Yes  No

No hernia

Asymptomatic hernia, no prior operation

Symptomatic hernia with or without incarceration

Successful repair

Recurrent hernia or size > 15 cm

chronic evisceration through large hernia with associated complication or multiple failed hernia repairs.

**32. Functional Status (AMBULATORY):** Yes  No

Do you have difficulty walking? Yes  No

Do you require a cane to walk? Yes  No

Can you walk more than 200 feet? Yes  No

Do you require a wheel chair? Yes  No

No impairment of functional status

Able to walk 200 ft with assistance device (cane or Crutch)

Cannot walk 200 ft with assistance device (cane or Crutch)

Requires wheel chair

Bedridden

**33. Abdominal Skin/Pannus:** Yes  No

Do you have a large pannus? Yes  No

Have you experienced:

skin irritation? Yes  No

infections? Yes  No

ulcerations? Yes  No

interference with ambulation? Yes  No

Have you required surgical treatment? Yes  No

No s/s

Intertriginous irritation

Pannus so large it interferes with ambulation

Recurrent cellulitis, Ulceration

Surgical treatment required

**MEDICATIONS/Vitamins/Minerals:**

Please list below all medications you currently use:

See attached list

Medication	Dose and Frequency	Purpose

Multi-Vitamins  Vitamin B12  Iron  Calcium with Vitamin D

Vitamin D  Calcium  Vitamin A, D, E Combo

**PAST MEDICAL HISTORY**

**Allergies:** Allergic to any medications?: Yes  No  If Yes, please list medication and reaction:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergic to:

**Surgical tape:** Yes  No  Reaction: \_\_\_\_\_

**Latex:** Yes  No  Reaction: \_\_\_\_\_

**Iodine:** Yes  No  Reaction: \_\_\_\_\_

Other Allergies:

\_\_\_\_\_  
\_\_\_\_\_

**Serious Illnesses:**

*Have you had:*

- Hepatitis  Blood Transfusion  AIDS/HIV Exposure
- Colitis  Kidney Disease  Bleeding Abnormality
- Heart Disease  Pulmonary Disease  Peptic Ulcer Disease
- Thyroid Problems \_\_\_\_\_

*Please list below all serious illnesses and hospitalizations you have experienced:*

Major Illness	Date	Treatment

**PAST SURGICAL HISTORY**

Major Surgery \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you had any problems with anesthesia? Y/N \_\_\_\_\_ Have you had any problems with wound infections? Y/N \_\_\_\_\_

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_ since \_\_\_\_\_  
 Mo day year

Marital Status: Single Married Divorced Widow

Live at: home Apartment with Spouse/Significant Other &/or Children (how many? \_\_\_\_\_)

Do you use **tobacco**: Yes  No  Frequency: \_\_\_\_\_  
 Are you willing to quit? Yes  No  or When did you quit? \_\_\_\_\_  
 Mo day year

Do you use **alcohol**: Yes  No  Frequency: \_\_\_\_\_

Do you use **drugs**: Yes  No  Frequency: \_\_\_\_\_

**FAMILY HISTORY**

Family Member	Living?	Age	Overweight?	If Deceased, Age	Illness/Cause of death
Mother			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Father			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Maternal Grandmother			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Maternal Grandfather			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Fraternal Grandmother			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Fraternal Grandfather			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Sibling:			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Sibling:			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Sibling:			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Sibling:			Yes <input type="checkbox"/> No <input type="checkbox"/>		

*Please indicate if there is a family history of:*

Lung disease, Asthma or Emphysema

- Diabetes
- High Blood Pressure
- Heart Disease
- High Blood Cholesterol
- Kidney Disease
- Bleeding tendency or Blood Disorder
- Breast Cancer
- Colon Cancer

**CHILDHOOD & OTHER PAST MEDICAL HISTORY**

*Please identify which of the following childhood illnesses you have experienced:*

- Measles
- Mumps
- Chickenpox
- Obesity
- Rheumatic fever
- Heart murmur
- Asthma
- Tonsillectomy

**Female Patients:**

Number of pregnancies: \_\_\_\_\_ Age at first period: \_\_\_\_\_

Number of live births: \_\_\_\_\_ Date of last period: \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_

Number of abortions: \_\_\_\_\_

Obstetric complications: \_\_\_\_\_

***Do you presently use:***

Birth control pills      Yes     No     List type: \_\_\_\_\_

Estrogens                Yes     No     List type: \_\_\_\_\_

Other Contraceptive method: \_\_\_\_\_

Tubal Ligation:    Yes  No     Laparoscopic or open

Hysterectomy :    Yes  No     Vaginal or Trans-abdominal (open)

## **SYSTEM REVIEW**

*Please circle all symptoms you currently experience, or have experienced in the past. Feel free to add any additional problems or information.*

**1. HEAD, EYE, EAR, NOSE & THROAT:** stuffy Nose – runny Nose – hay fever – sinus trouble – earache – headache – blurry vision – double vision – haloes around lights – loss of night vision – buzzing in ears – ringing in ears – discharge from ear – loss of hearing – dizziness – vertigo – loss of balance – sore throat – lump in throat – trouble swallowing – pain with swallowing – hoarseness

**2. RESPIRATORY:** cough – wheezing – shortness of breath at night – use of two pillows – blood in sputum – out of breath with exertion – wake up at night short of breath – wake up at night coughing or choking – asthma – emphysema – bronchitis

**3. CARDIOVASCULAR:** palpitations – pounding heart – skipping heartbeat – pains in chest – pains in neck – pains in arms – squeezing of chest – heart attack – heart murmur – abnormal electrocardiogram – irregular heartbeat – high blood pressure – pain in legs – cold feet – blue toes – blue finger – loss of pulses

**4. GASTROINTESTINAL:** heartburn – nausea – vomiting – belching fluid in throat – burning in throat – food sticking in chest – pains in stomach – burning in stomach – acid stomach – diarrhea – constipation – pain with bowel movement – blood in stools – hemorrhoids – fissures – cramps – gassiness – irritable colon – colitis

**5. GENITOURINARY:** pain with urination – trouble starting urine – trouble stopping urine – small urine stream – blood in urine – kidney stones – bladder stones – kidney failure – nephritis – urinary tract infections – frequent urination – getting up at night to urinate – leakage of urine with cough or sneeze

◆Men: discharge from penis – loss of erection – painful erection

◆Women: vaginal discharge – vaginal bleeding – pain with intercourse – irregular periods

**6. ENDOCRINE (GLANDULAR):** low thyroid – hyperthyroid – goiter – Grave's Disease – thyroid Nodules – xray to thyroid – diabetes – adrenal gland tumor – frequent flushing – frequent heavy sweating

**7. MUSCULOSKELETAL:** pain in joints – swelling of joints – redness of skin over joints – warm joints – fluid in joints – arthritis – broken bones – sprains – low back pain – hip pain – knee pain – ankle pain – foot pain – flat feet – slipped disk – herniated disk – sciatica

**8. NEUROLOGICAL:** dizziness – vertigo – falling to the side – falling at night – numbness – tingling – pins and needles feelings – weakness of any muscles – twitching of muscles – weakness of grip – shakiness – tremors – fainting – convulsions – fits – loss of consciousness

**PSYCHOLOGICAL:** nervousness – anxiety – depression – thoughts of suicide – suicide attempts – hospitalization for emotional problems – psychiatric treatment – psychological counseling

**PERSONAL PHYSICIANS:**

*Please list all the physicians under whom you receive medical care:*

	Name	Address/Location	Telephone
Primary Care Physician	_____	_____	_____
Internist	_____	_____	_____
Cardiologist	_____	_____	_____
Gynecologist	_____	_____	_____
Orthopedist	_____	_____	_____
Psychiatrist	_____	_____	_____
Psychologist	_____	_____	_____
Therapist	_____	_____	_____
Nutritionist	_____	_____	_____
Other (Specify)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____



