

SYSTEMS

DO YOU NOW HAVE OR HAVE YOU EVER HAD	NO	YES	DO YOU NOW HAVE OR HAVE YOU EVER HAD	NO	YES
ANY <input type="checkbox"/> EYE DISEASE <input type="checkbox"/> EYE INJURY <input type="checkbox"/> IMPAIRED SIGHT			KIDNEY <input type="checkbox"/> DISEASE <input type="checkbox"/> STONES		
ANY <input type="checkbox"/> EAR DISEASE <input type="checkbox"/> EAR INJURY <input type="checkbox"/> IMPAIRED HEARING			BLADDER DISEASE		
ANY TROUBLE WITH <input type="checkbox"/> NOSE <input type="checkbox"/> SINUSES <input type="checkbox"/> MOUTH <input type="checkbox"/> THROAT			BLOOD IN URINE		
FAINING SPELLS			<input type="checkbox"/> ALBUMIN <input type="checkbox"/> SUGAR <input type="checkbox"/> PUS <input type="checkbox"/> ETC. IN URINE		
CONVULSIONS			DIFFICULTY IN URINATION		
PARALYSIS			NARROWED URINARY STREAM		
DIZZINESS			ABNORMAL THIRST		
HEADACHES: <input type="checkbox"/> FREQUENT <input type="checkbox"/> SEVERE			PROSTATE TROUBLE		
ENLARGED GLANDS			<input type="checkbox"/> STOMACH TROUBLE <input type="checkbox"/> ULCER		
THYROID: <input type="checkbox"/> OVERACTIVE <input type="checkbox"/> UNDERACTIVE <input type="checkbox"/> ENLARGED			INDIGESTION		
ENLARGED GOITER			<input type="checkbox"/> GAS <input type="checkbox"/> BELCHING		
SKIN DISEASE			APPENDICITIS		
COUGH: <input type="checkbox"/> FREQUENT <input type="checkbox"/> CHRONIC			<input type="checkbox"/> LIVER DISEASE <input type="checkbox"/> GALL BLADDER DISEASE		
<input type="checkbox"/> CHEST PAIN <input type="checkbox"/> ANGINA PECTORIS			<input type="checkbox"/> COLITIS <input type="checkbox"/> OTHER BOWEL DISEASE		
SPITTING UP BLOOD			<input type="checkbox"/> HEMORRHOIDS <input type="checkbox"/> RECTAL BLEEDING		
NIGHT SWEATS			BLACK TARRY STOOLS		
SHORTNESS OF BREATH <input type="checkbox"/> EXERTION <input type="checkbox"/> AT NIGHT			<input type="checkbox"/> CONSTIPATION <input type="checkbox"/> DIARRHEA		
<input type="checkbox"/> PALPITATION <input type="checkbox"/> FLUTTERING HEART			<input type="checkbox"/> PARASITES <input type="checkbox"/> WORMS		
SWELLING OF <input type="checkbox"/> HANDS <input type="checkbox"/> FEET <input type="checkbox"/> ANKLES			<input type="checkbox"/> ANY CHANGE IN APPETITE <input type="checkbox"/> EATING HABITS		
VARICOSE VEINS			<input type="checkbox"/> ANY CHANGE IN BOWEL ACTION <input type="checkbox"/> STOOLS		
EXTREME <input type="checkbox"/> TIREDNESS <input type="checkbox"/> WEAKNESS			EXPLAIN		

IMMUNIZATION - EKG

HAVE YOU HAD	NO	YES	HAVE YOU HAD	NO	YES
SMALLPOX VACCINATION (WITHIN LAST 7 YEARS)			POLIO SHOTS (WITHIN LAST 2 YEARS)		
TETANUS SHOT (NOT ANTITOXIN)			AN ELECTROCARDIOGRAM		WHEN

HABITS

DO YOU	NO	YES	DO YOU USE	NEVER	OCC.	FREQ.	DAILY
EXERCISE ADEQUATELY			LAXATIVES				
HOW?			VITAMINS				
AWAKEN RESTED			SEDATIVES				
SLEEP WELL			TRANQUILIZERS				
AVERAGE 8 HOURS SLEEP (PER NIGHT)			SLEEPING PILLS, ETC.				
HAVE REGULAR BOWEL MOVEMENTS			ASPIRINS, ETC.				
SEX - ENTIRELY SATISFACTORY			CORTISONE				
LIKE YOUR WORK (HOURS PER DAY) <input type="checkbox"/> INDOORS <input type="checkbox"/> OUTDOORS			ALCOHOLIC BEVERAGES				
WATCH TELEVISION (HOURS PER DAY)			COFFEE (CUPS PER DAY)				
READ (HOURS PER DAY)			TOBACCO: <input type="checkbox"/> CIGARETTES (PKS PER DAY)				
HAVE A VACATION (WEEKS PER YEAR)			<input type="checkbox"/> CIGARS <input type="checkbox"/> PIPE <input type="checkbox"/> CHEWING TOBACCO				
HAVE YOU EVER BEEN TREATED FOR ALCOHOLISM			<input type="checkbox"/> SNUFF				
HAVE YOU EVER BEEN TREATED FOR DRUG ABUSE			APPETITE DEPRESSANTS				
RECREATION: DO YOU PARTICIPATE IN SPORTS OR HAVE HOBBIES WHICH GIVE YOU RELAXATION AT LEAST 3 HOURS A WEEK.			THYROID MEDICATION: <input type="checkbox"/> NO <input type="checkbox"/> YES, IN PAST <input type="checkbox"/> NONE NOW NOW ON GR. DAILY				
			HAVE YOU EVER TAKEN ...				
			<input type="checkbox"/> INSULIN <input type="checkbox"/> TABLETS FOR DIABETES <input type="checkbox"/> HORMONE SHOTS <input type="checkbox"/> TABLETS <input type="checkbox"/> NO				

WOMEN ONLY

MENSTRUAL HISTORY	NO	YES	ARE YOU REGULAR: <input type="checkbox"/> HEAVY <input type="checkbox"/> MEDIUM <input type="checkbox"/> LIGHT	NO	YES
AGE AT ONSET			DO YOU HAVE <input type="checkbox"/> TENSION <input type="checkbox"/> DEPRESSION BEFORE PERIOD		
USUAL DURATION OF PERIOD DAYS			DO YOU HAVE <input type="checkbox"/> CRAMPS <input type="checkbox"/> PAIN WITH PERIOD		
CYCLE (START TO START) DAYS			DO YOU HAVE HOT FLASHES		
DATE OF LAST PERIOD					
PREGNANCIES	NO	YES		NO	YES
CHILDREN BORN ALIVE (HOW MANY)			STILL BORN (HOW MANY)		
CESAREAN SECTIONS (HOW MANY)			MISCARRIAGES (HOW MANY)		
PREMATURES (HOW MANY)			ANY COMPLICATIONS		

EMOTIONS

ARE YOU OFTEN	NO	YES	ARE YOU OFTEN	NO	YES
DEPRESSED			JUMPY		
ANXIOUS			JITTERY		
IRRITABLE			IS CONCENTRATION DIFFICULT?		