

Social Habits. (Continued)

Alcohol Use

- Never
- Occasionally
- Daily (or regularly)
- Previously (but quit)

Tobacco Use

- Yes
Cigarettes per day: _____
- Never
- Previously (but quit)

Recreational Drug Use

- Never
- Occasionally
- Daily (or regularly)
- Previously (but quit)

Participated in drug or alcohol rehabilitation program

Body tattoos or piercing? _____

Family History. (Does anyone in your family have the following?)

Liver Disease:	Hypertension:	
Kidney Disease:	Heart Disease	
Diabetes:	Cancer:	
Bleeding Disorder:	Stroke:	
Other:		
Alive/Deceased (Circle Yes/No)	Age(s)	Health Problems
Mother Yes/No		
Father Yes/No		
Number of Siblings		
Number of Children		

Patient Health Inventory Summary

General		Musculoskeletal	
<input type="checkbox"/>	Fever	<input type="checkbox"/>	Joint Pain/Swelling
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Muscle/Joint Weakness
<input type="checkbox"/>	Recent weight change	<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Pain with Walking
<input type="checkbox"/>	Stress	<input type="checkbox"/>	Cold Extremities
<input type="checkbox"/>	Chills /night sweats	<input type="checkbox"/>	Numbness/Tingling in Arms or Legs
		<input type="checkbox"/>	Varicose Veins
Eyes, Ears, Nose, Mouth, Throat		Breast	
<input type="checkbox"/>	Eye/Vision Problems	<input type="checkbox"/>	Family history of breast cancer
<input type="checkbox"/>	Hearing Loss/Ringing	<input type="checkbox"/>	Breast Pain or Lump
<input type="checkbox"/>	Dental Problems Date of last dental exam:	<input type="checkbox"/>	Nipple Discharge/Bleeding
<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	Any lump in armpit
<input type="checkbox"/>	Frequent Colds	Skin	
<input type="checkbox"/>	Earaches	<input type="checkbox"/>	Rash/Itching
<input type="checkbox"/>	Sore Throat/Hoarseness	<input type="checkbox"/>	Bleeding/Bruising
<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	Change in Skin/Hair/Nails
Heart & Lungs		Neurologic/Psychologic	
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Frequent Headaches
<input type="checkbox"/>	Irregular/Fast Heartbeat	<input type="checkbox"/>	Lightheaded/Dizzy
<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	Swelling of Feet/Ankles	<input type="checkbox"/>	Depression/ Psychiatric problems
<input type="checkbox"/>	Cough	Endocrine	
<input type="checkbox"/>	Asthma/Wheezing	<input type="checkbox"/>	Glandular/Hormone Problem
<input type="checkbox"/>	Coughing up phlegm	<input type="checkbox"/>	Excessive Thirst or Urination
<input type="checkbox"/>	Spitting up Blood	<input type="checkbox"/>	Heat or Cold Intolerance
<input type="checkbox"/>	Phlegm production	<input type="checkbox"/>	Thyroid problems

Gastrointestinal		Blood Transfusions	
<input type="checkbox"/>	Loss of Appetite	When	
<input type="checkbox"/>	Nausea/Vomiting	Where	
<input type="checkbox"/>	Diarrhea	# Received	
<input type="checkbox"/>	Constipation	Past or Current Infections	
<input type="checkbox"/>	Change in Bowels	<input type="checkbox"/>	Chicken pox/Shingles
<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Hepatitis A / B / C
<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	HIV
<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	Herpes / Warts
<input type="checkbox"/>	Colonoscopy	<input type="checkbox"/>	Tuberculosis
		<input type="checkbox"/>	Other infections
Genitourinary		Males Only	
<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	Pain or Swelling in Testicle
<input type="checkbox"/>	Pain or Burning with Urination	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	Bladder Control Problems	<input type="checkbox"/>	Erectile dysfunction
<input type="checkbox"/>	Blood in Urine	Females Only	
<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Severe Cramps or Irregular Menses
<input type="checkbox"/>	Change in Force or Stream	<input type="checkbox"/>	Last Menstrual period
<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	Last Pap Smear
<input type="checkbox"/>	Decreased Daily Volume of Urine	<input type="checkbox"/>	Any Abnormal Pap Smear in Past
<input type="checkbox"/>	Estimate Volume of Urine Per Day	<input type="checkbox"/>	Last Mammogram
<input type="checkbox"/>	Date last prostate exam	<input type="checkbox"/>	Any Abnormal Mammograms in Past
	Bleeding Disorders	<input type="checkbox"/>	How many Previous Pregnancies
<input type="checkbox"/>	Slow to Heal after Cuts	<input type="checkbox"/>	How many Full-Term Deliveries
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	How many Miscarriages
<input type="checkbox"/>	Blood Clots or Phlebitis	<input type="checkbox"/>	Family History of Breast Cancer
<input type="checkbox"/>	Do you have religious concerns regarding blood transfusions?	<input type="checkbox"/>	Taking hormone replacements?
<input type="checkbox"/>	Do you have ethical concerns regarding blood transfusions?	<input type="checkbox"/>	Birth control pills?

Are you being worked up or listed at another center?

If YES, name of center _____

Signature: _____

Date _____