11. Have you or any immediate family members ever been told you have (please circle your answer)		
	Self	Family
Cancer?	YesNo	YesNo
Diabetes?	YesNo	YesNo
High Blood Pressure?	YesNo	YesNo
Heart Disease?	YesNo	YesNo
Angina/ chest pain?	YesNo	YesNo
Stroke?	YesNo	YesNo
Osteoporosis?	YesNo	YesNo
Osteoarthritis?	YesNo	YesNo
Rheumatoid Arthritis?	YesNo	YesNo
12. In the Past 3 months have you had or do yo	u experience: (please circle your a	nswer)
A change in your health?	YesNo	
Nausea/Vomiting?	YesNo	
Fever/chills/sweats?	YesNo	
Unexplained weight Change?	YesNo	
Numbness or tingling?	YesNo	
Changes in appetite?	YesNo	
Difficulty swallowing?	YesNo	
Changes in bowel or bladder function?	YesNo	
Shortness of Breath?	YesNo	
Dizziness?	YesNo	
Upper Respiratory infection?	YesNo	
Urinary Tract infection?	YesNo	
Pregnancy?	YesNo	
13. Do you have a history of: (please circle yo	ur answer)	
Allergies/Asthma?	YesNo	
Headaches?	YesNo	
Bronchitis?	YesNo	
Kidney disease?	YesNo	
•		
Rheumatic Fever?	YesNo	
Ulcers?	YesNo	
Sexually transmitted disease?	YesNo	
Seizures?	YesNo	
14. How are you able to sleep at night? (c	check one)	
[] Fine [] Moderate di		ion
15. Do you have a problem with (c	check all that apply)	
[] Hearing [] Speech	[] Vision [] Communica	tion
16. Date of last physical examination	[] communication	
		
17. List medications currently using: Name	Dosage	Frequency
		
		
		
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