

PAST MEDICAL HISTORY:

1. List major health problems/diseases for which you have received treatment or for which you have been hospitalized; now or in the past.

2. List all surgeries either as an in-patient or out-patient.

3. List current medications and dosages.

List vitamins and over the counter medications: _____

List supplements: _____

4. List allergies to medicines and any reactions.

5. List allergies to other substances and any reactions.

6. Any previous history of childhood allergies or asthma Yes No

7. List serious injuries from accidents (broken bones, head injuries, etc.).

8. Immunizations: Did you receive childhood immunizations? Yes No; Pneumovax? Yes No
Date of your last tetanus shot? _____ Date of last flu shot? _____

SOCIAL HISTORY:

Tobacco Use

1. Have you ever smoked cigarettes? Yes No
(No means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year.)

If YES to Question #1

A. Do you now smoke cigarettes (as of one month ago)? Yes No

B. How old were you when you first started regular cigarette smoking? (Age in years) _____

C. If you have stopped smoking cigarettes completely, how old were you when you stopped?
..... (Age in years) _____

D. How many cigarettes do you smoke per day now? _____

E. On the average of the entire time you smoked, how many cigarettes did you
smoke per day? _____

F. Do you or did you inhale the cigarette smoke? Not at all Slightly Moderately Deeply



PATIENT ID #:

2. Have you ever smoked a pipe regularly? Yes No
(Yes means more than 12 oz. of tobacco in a lifetime)

If YES to Question #2

A. 1. How old were you when you started to smoke a pipe regularly? . . (Age in years) _____

2. If you have stopped smoking a pipe completely, how old were you when you stopped?
..... (Age in years) _____

3. Are you still smoking a pipe? Yes No

B. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week?
_____ oz. per week (a standard pouch of tobacco contains 1-1/2 oz.)

C. How much pipe tobacco are you smoking now? _____ oz. per week.

D. Do you or did you inhale the pipe smoke? Not at all Slightly Moderately Deeply

3. Have you ever smoked cigars regularly? Yes No
(Yes means more than 1 cigar a week for a year).

If YES to Question #3

A. 1. How old were you when you started smoking cigars regularly? . . (Age in years) _____

2. If you stopped smoking cigars completely, how old were you when you stopped?
..... (Age in years) _____

3. Are you still smoking cigars? Yes No

B. On the average over the entire time you smoked cigars, how many cigars did you
smoke per week? _____

C. How many cigars are you smoking now? _____ per week.

D. Do you or did you inhale the cigar smoke? Not at all Slightly Moderately Deeply

4. Have you ever used smokeless tobacco regularly? Yes No

If YES to Question #4

A. 1. How old were you when you started using smokeless tobacco regularly? (Age in years) _____

2. If you stopped using smokeless tobacco completely, how old were you when you stopped?
..... (Age in years) _____

3. Are you still using smokeless tobacco? Yes No

B. On the average over the entire time you used smokeless tobacco, how much did you
use per week? _____

C. How much are you using per week now? _____ per week.

Alcohol Use (list amount of alcoholic beverages consumed each day/week/month)

A. Do you drink alcohol? Yes No

B. What type of alcoholic beverages do you drink? _____

C. How many per day? _____

List your hobbies/recreational activities:



List your environmental exposures:

- A. How long have you been living at your current residence: . . . _____
 - B. Age of house: _____
 - C. Type of home heating system: _____
 - D. Water source: _____
 - E. Pets: _____
 - F. Recent/current residential remodeling, if yes, when: _____
 - G. Do you live close to farms, factories, highways, dump sites, other Yes No
- If YES to Question G, Please give Details, if necessary: _____
- _____
- _____

How Many Persons Are Currently Living In Your Household _____

How Much Schooling Did You Complete? (last level completed 1-17+ years) _____

Should the New York State Department of Health wish to conduct future studies, would you be willing to be contacted for possible participation? Yes No

FAMILY HISTORY (Please list major illnesses of family members):

	Living	Age if Living or Age at Death	Major Illnesses
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Siblings – List your Brothers and Sisters with ages and illness			
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Children – List your Sons and Daughters with ages and illness			
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Relatives – with ages and illness			
	<input type="checkbox"/> Yes <input type="checkbox"/> No		



OCCUPATIONAL HISTORY: List the jobs you've had since you first started working. Also include the years worked at each job. Include any military service. Use the next page if additional space is needed.

DATE	EMPLOYER NAME, PRODUCT OR SERVICE PROVIDED	JOB TITLE/DUTIES	MAJOR EXPOSURES <small>(for example: dusts, chemicals, noise, repetitive motion, stress)</small>	CO-WORKERS WITH SYMPTOMS? ATTEMPTS TO FIX PROBLEM?	PROTECTIVE EQUIPMENT <small>(for example: respirator, hearing protection, gloves)</small>
EXAMPLE: 1987-1989	EXAMPLE: ACME INDUSTRIES SHOE POLISH MANUFACTURER	EXAMPLE: INSPECTOR	EXAMPLE: SHOE POLISH, SOLVENTS, TRICHLOROETHYLENE	EXAMPLE: CO-WORKERS W/HEADACHES FANS PUT NEAR MACHINES	EXAMPLE: RESPIRATOR, EAR PLUGS



PATIENT ID #:

REVIEW OF SYSTEMS

Please check ANY symptoms which you have experienced in the past three (3) months.

- General:** weight change weakness
 heat intolerance night sweats
 chills excessive thirst
 fever cold intolerance
-

- Skin:** persistent rash persistent itching
-

- Head, Ears, Eyes,** dizziness jaw pain (TMJ)
Nose, Throat: fainting spells dental problems
 frequent headaches dentures
 severe headaches difficulty chewing
 sinus trouble difficulty swallowing
 sinus congestion hoarseness
 nasal congestion frequent colds
 runny nose neck swelling
 sneezing poor eyesight
 post nasal drip double vision
 loss of smell watery, itchy eyes
 change in smell hearing trouble
 loss of taste ringing in ears
 bad taste in mouth hearing aid
 sores in mouth ear ache
 bleeding gums ear discharge
-

- Lungs:** cough phlegm
 wheezing chest pain with deep breathing
 shortness of breath coughing blood
-

- Heart:** chest discomfort or pain irregular heartbeat
 swollen ankles leg or calf pain when walking
 shortness of breath laying down flat wake up gasping for breath
-

- Gastrointestinal:** change in appetite change in bowel habits
 frequent or severe heartburn constipation
 frequent or severe nausea prolonged or frequent diarrhea
 frequent or severe vomiting blood in bowel movements
 vomiting blood black bowel movements
 frequent or severe abdominal pain hemorrhoids
 frequent bloating yellow jaundice
-

- Urinary:** frequent urination painful urination
 bloody urine difficulty urinating
 urinating more than 2 times per night
-

Bones, Joints, Muscles: joint pain
 muscle aches or cramps/tightness

joint swelling
 varicose veins

Nervous System: tingling (pins & needles)
 difficulty with balance
 tremor (shaking, trembling)
 convulsions (seizures, fits, epilepsy)
 fainting spells or blackouts
 lack of energy
 trouble sleeping
 nervousness
 trouble concentrating

memory troubles
 confusion
 depression
 crying spells
 mood swings
 trouble getting along with people



PATIENT ID #:

REVIEW OF SYSTEMS: *continued*

Please check ANY symptoms which you have experienced in the past three (3) months.

- Men:** discharge from penis lump or pain in testicle
 loss of sex drive sexual trouble
-

- Woman:** breast lump or discharge discharge from vagina
 unusual bleeding from vagina loss of sex drive
 sexual trouble
-

- Both:** Difficulty (you or partner) in becoming pregnant.

Has your illness/injury affected you ability to perform the following:

- tasks around the house
- care for family/children
- recreation
- no affect