PREVENTIVE

	DATE		DATE		DATE
SIGMOIDOSCOPY:	_____	PAP SMEAR	_____	EYE EXAM	_____
MAMMOGRAM:	_____	BREAST EXAM	_____	STOOL CK FOR BLOOD	_____
COLONOSCOPY:	_____	PROSTATE EXAM	_____	CHOLESTEROL CK:	_____

FAMILY HISTORY

HAS ANY MEMBER OF THE FAMILY (INCLUDING PARENTS AND SIBLINGS) EVER HAD THE FOLLOWING?

ILLNESS	WHICH FAMILY MEMBER(S)?	AGE DIAGNOSED
CANCER (DESCRIBE WHICH TYPE)		
HYPERTENSION (HIGH BLOOD PRESSURE)		
HEART DISEASE		
DIABETES		
STROKE		
MENTAL DISEASE(ANIETY,DEPRESSION ETC)		
DRUG OR ALCOHOL ADDICTION		
GLAUCOMA		
BLEEDING DISEASE		
OTHER		

REVIEW OF SYSTEMS

DO YOU HAVE FREQUENT HEADACHES?	YES_____	NO_____
DO YOU DIFFICULTY HEARING?	YES_____	NO_____
DO YOU HAVE TROUBLE SWALLOWING?	YES_____	NO_____
HAVE YOU HAD ANY UNINTENTIONAL WEIGHT LOSS?	YES_____	NO_____
DO YOU HAVE DIFFICULTY BREATHING?	YES_____	NO_____
DO YOU HAVE FREQUENT CHEST PAIN?	YES_____	NO_____
DO YOU SUFFER FROM FREQUENT ABDOMINAL PAIN?	YES_____	NO_____
DO YOU HAVE FREQUENT DIARRHEA?	YES_____	NO_____
ARE YOU FREQUENTLY CONSTIPATED?	YES_____	NO_____
DO YOU SUFFER FROM SEXUAL DYSFUNCTION?	YES_____	NO_____
DO YOU HAVE TROUBLE URINATING?	YES_____	NO_____
ARE YOU HAVING TROUBLE WALKING?	YES_____	NO_____
DO YOU HAVE FREQUENT BACK PAIN?	YES_____	NO_____

PLEASE ELABORATE ON ANY OF THE ABOVE ANSWERS:

DOCTOR: _____

(PRINT NAME)

_____ _____