

Patient Name: _____ Date Completed: __/__/____

Please check any conditions diagnosed and/or treated (currently or in the past):

(Please check with your Study Coordinator if you have any questions.)

<p><u>Ear, Nose and Throat</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Hearing Problems<input type="checkbox"/> Ringing in Ears (Tinnitus)<input type="checkbox"/> Dizziness (Vertigo) <p><u>Ophthalmic (Eyes)</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Glaucoma<input type="checkbox"/> Cataracts<input type="checkbox"/> Diabetic Retinopathy <p><u>Respiratory</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Allergic Rhinitis (Perennial or Seasonal)<input type="checkbox"/> Asthma<input type="checkbox"/> Chronic Bronchitis<input type="checkbox"/> Shortness of Breath<input type="checkbox"/> Emphysema/Chronic Obstructive Pulmonary Disease (COPD)<input type="checkbox"/> Tuberculosis<input type="checkbox"/> Sleep Apnea <p><u>Cardiovascular</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Heart Murmur/Heart Valve Defects<input type="checkbox"/> Heart Bypass Surgery/Stent to Artery/Angioplasty<input type="checkbox"/> Angina/Chest Pain<input type="checkbox"/> Heart Attack<input type="checkbox"/> Congestive Heart Failure<input type="checkbox"/> High Blood Pressure<input type="checkbox"/> Palpitations or Irregular Heartbeat<input type="checkbox"/> Edema (Swollen Feet/Legs)<input type="checkbox"/> High Cholesterol/High Lipids	<p><u>Gastrointestinal</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Stomach Ulcer/GI Bleed<input type="checkbox"/> Gallstones/Gallbladder Problems<input type="checkbox"/> Hernia<input type="checkbox"/> Heartburn and/or GERD (reflux)<input type="checkbox"/> Diarrhea or Constipation<input type="checkbox"/> Crohns Disease/Inflammatory Bowel Disease<input type="checkbox"/> Irritable Bowel Syndrome (IBS)<input type="checkbox"/> Diverticular Disease<input type="checkbox"/> Pancreatitis <p><u>Liver</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Hepatitis <p><u>Urogenital</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Kidney Stones<input type="checkbox"/> Over-Active Bladder<input type="checkbox"/> Urinary Incontinence<input type="checkbox"/> STD/HIV<input type="checkbox"/> Decreased Libido (Loss of Sexual Desire)<input type="checkbox"/> Prostate Problems/BPH/Enlarged Prostate<input type="checkbox"/> Erectile Dysfunction/Impotence/Rapid Ejaculation<input type="checkbox"/> Hot Flashes/Other Menopausal Symptoms <p><u>Hematological (Blood)</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Anemia or Bleeding Disorders<input type="checkbox"/> Frequent Blood/Plasma Donor
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Revised: 11-04-2010

Implemented: 01-03-2011

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(Please check with your Study Coordinator if you have any questions.)

<p><u>Neurological</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Epilepsy or Seizures<input type="checkbox"/> Stroke or TIA (“mini-stroke”)<input type="checkbox"/> Parkinson’s Disease<input type="checkbox"/> Dementia/Alzheimer’s Disease<input type="checkbox"/> Insomnia (Trouble Sleeping)<input type="checkbox"/> Migraine Headaches/Tension Headaches/Cluster Headaches<input type="checkbox"/> Shingles<input type="checkbox"/> Neuropathy <p><u>Endocrine (Glands)</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Thyroid Problems<input type="checkbox"/> Diabetes (Type I or II) <p><u>Musculoskeletal</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Osteoarthritis<input type="checkbox"/> Rheumatoid Arthritis<input type="checkbox"/> Chronic Back Pain<input type="checkbox"/> Osteoporosis<input type="checkbox"/> Gout<input type="checkbox"/> Fibromyalgia <p><u>Skin</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Acne<input type="checkbox"/> Rosacea<input type="checkbox"/> Psoriasis<input type="checkbox"/> Eczema	<p><u>Psychiatric</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Depression<input type="checkbox"/> Anxiety/Panic Disorder <p><u>Other</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Obesity/Weight Loss Surgery<input type="checkbox"/> Cancer <p>Y or N Are you allergic to any medicines?</p> <p>If yes, please specify which: _____</p> <p>_____</p> <p>_____</p> <p>Please list any past surgeries, hospitalizations or procedures (ex: colonoscopy, endoscopy):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Other conditions diagnosed and/or treated that are not listed above:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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