14. Have you had or do presently have any of the following:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Headache | | Yes | | No | | Vision | | Yes | | No |
| Hearing Problems | | Yes | | No | | Dizziness | | Yes | | No |
| Seizure | | Yes | | No | | Chest Pain | | Yes | | No |
| Difficulty Swallowing | | Yes | | No | | Stomach Pain | | Yes | | No |
| Shortness of Breath | | Yes | | No | | Urinary Problems | | Yes | | No |
| Nausea | | Yes | | No | | Vomiting | | Yes | | No |
| Constipation | | Yes | | No | | Diarrhea | | Yes | | No |
| Rashes | | Yes | | No | | Swollen Joints | | Yes | | No |
| Chronic Fatigue | | Yes | | No | | Smoking (how many pack (  ) | | Yes | | No |
| Diabetes | | Yes | | No | | Thyroid Disease | | Yes | | No |
| High Blood Pressure | | Yes | | No | | Stoke | | Yes | | No |
| Heart Disease | | Yes | | No | | Heart Attack | | Yes | | No |
| Pacemaker | | Yes | | No | | Psychiatric Hospitalization | | Yes | | No |
| Metal Implants | | Yes | | No | | Alcohol/Substance Abuse | | Yes | | No |
| Asthma | | Yes | | No | | Lyme disease | | Yes | | No |
| HIV/AIDS | | Yes | | No | | Other | | Yes | | No |

15.

**TUBERCULOSIS (TB) SCREENING QUESTIONS If "YES"** to any of these questions, refer patient to physician

1. Unexplained cough lasting for longer than three (3) weeks? □ YES □ NO
2. Unexplained fever or chills for longer than three (3) days? □ YES □ NO

16. Are you presently taking any medication? (Prescription and /or non-prescription) □ YES □ NO

| **MEDICATION:** | **CONDITION** |
|---|---|
| _____ | _____ |
| _____ | _____ |

17. Are you allergic to any drugs or medications. Food or other agents, etc? □ YES □ NO

| (IF YES, LIST) DRUG | REACTION |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

18. If you no longer smoke, please indicate when you **QUIT**? _____

19. How much alcohol do you normally consume in a week? _____

20. How many cups or glasses of caffeine-containing beverages do you normally consume in a day? _____

21. Is there any additional information you need to tell the physician that should be concerning to your past health? _____

_____

_____ _____ _____

Pls. print your name Signature Date