GENERAL

1. TEND TO BE TO HOT OR COLD? _____YES _____NO
2. LOSS OF INTEREST IN EATING? _____YES _____NO
3. ALWAYS HUNGRY? _____ YES _____NO
4. MORE THIRSTY LATELY? _____ YES _____NO
5. ARMPITS OR GROIN SWELLING? _____ YES _____NO
6. EXHAUSTED OR FATIGUED? _____ YES _____NO
7. SLEEP DIFFICULTIES? _____ YES _____NO
8. DO YOU EXERCISE AT LEAST 3 TIMES PER WEEK? _____YES _____NO
9. TWO OR MORE ALCOHOLIC DRINKS PER DAY? _____YES _____NO
10. USE SLEEPING PILLS, MARIJUANA, TRANQUILIZERS? _____YES _____NO
11. HAS USED HARD DRUGS? _____YES _____NO
12. DO YOU WEAR A SEATBELT? _____YES _____NO

DATE		DATE	
_____	CHEST X-RAY	_____	CHOLESTEROL TEST
_____	COLON X-RAY	_____	MAMMOGRAM
_____	EKG	_____	PAP SMEAR
_____	TB TEST	_____	PROSTATE TEST
_____	SIGMOIDOSCOPY	_____	EYE EXAM

_____ _____

PATIENT SIGNATURE **DATE**

COMMENTS:_____

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