Welcome

Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

1. Personal Information

Home Phone:_____

Date:		
Wishes to be called:		
☐ Male ☐ Female ☐ Minor	□ Single □ Married □	Divorced 🗌 Widowed 🗌 Separated
Address:		
City:	State:	Zip/PC:
E-mail:		
Employer:		n:
Referred by:		
2. Responsible Party <i>Who is responsible for the accoun</i>	<i>t</i> ?	
Name:		
Relationship to patient:	Bir	thdate:
Address:		
City:		Zip/PC:
E-mail:		
		1:
Work Phone:	Ext	#:

Cell Phone:_____

3. Telephone

Employer:		_Occupation:			
Work Phone:		Ext#	! <u></u>		
Home Phone:		Cell	Phone:		
Where do you prefer to rece	eive calls: 🗌 Home	□ Work			
When is the best time to rea	ach you? 🔲 Time	🗌 Days			
In the event of an emergend	cy, who should we cont	act?			
Name	Relationship	Wor	k#	Home#	

4. Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services, I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient or parent/guardian if minor Date

5. Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full at each appointment	Late Charges If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of $1/5\%$ on the balance then
Cash	late charge of 1/5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that
Personal Check	failure to keep this account current may result in you being unable to provide
Credit Card:VisaMC	additional services except for emergencies or where there is prepayment for additional
I wish to discuss the office's payment policy.	services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.

Patent Consent, Waiver & Release

Acupuncture is a form of treatment that has been in existence for at least three thousand years. It's part of a holistic system of medicine that takes a person's body, emotions, activities, diet and environment into consideration.

Acupuncture works on the body's life force, a quality no yet measurable by machines. The Chinese word for this force is "qi", pronounced "chee". Think of it as the body's electrical system. Most of our muscles function because of electrical charges that flow throughout our cells, or along certain pathways called meridians.

A reduction, increase, or blockage of that flow of energy may result in pain, dysfunction and or/disease. Acupuncture does not cure, or even treat "diseases". Rather, it strives to balance that energetic flow, which allows the body to heal itself.

Occasionally, a patient will experience some side-effects, such as bruising or soreness (at the needle site), light-headedness, fatigue, and/or temporary increase in pain. These effects never last long. Often this is a sign the treatment is working. However, be sure to advise your practitioner if you experience any such effects.

Acupuncture treatment is often accompanied by recommendations for herbal treatment, or dietary changes, or exercises, which are intended to enhance the ability of the body to heal itself.

Herbal treatment can be recommended either alone or as a companion treatment with traditional Western medicine. Such herbal treatment may affect patients differently; depending upon the length, severity, type, treatment of, and other medication prescribed for, their illness.

As part of consideration of the efforts made to alleviate pain, increase energy and improve my physical condition; I, the undersigned, consent to treatment, waive and release any and all rights and claims for damages I may have against William Christopher Powell, aka Chris Powell, Missouri Acupuncture Services, and their representatives, volunteers, employees, successors and assigns, or any of them, for Any and all injuries and/or losses suffered by me through treatment or as a result of treatment.

Date: _____ Signature: _____

Medical History Form



			6: 1	D' 1		
Name		Age	Single Married	Divorced Widow(er)	Date	
Occupation	All Previous Occupations					
Birth Place Birthdate			List all State which you h			
Education:years High School		years	College		уе	ars Post Grad
Date of last physical examination Please list all Symptoms		NOTE : This is a confidential contained here will not be rele order.				
1		To the best of my knowledge,				
2		providing incorrect informati- inform the doctor's office of a staff to perform the necessary	ny changes in my (my child	's) medical status		
3		PATIENT SIGNATURE	C			
4						
5		PHYSICIAN'S REVIEW	SIGNATURE			
Routine Check-up - No Symptoms						
If Living		f Deceased	Has any blood	Please	encircle	
Age Health	Age at death	Cause	relative ever had:	No o	r Yes	Who
Father		Contrastic Contrastico de la	Cancer	No	Yes	
Mother			Tuberculosis	No	Yes	
Brother or Sister 1.			Diabetes	No	Yes	
2.			Heart Trouble	No	Yes	
3.			High Blood			
4.			Pressure	No	Yes	
Husband or Wife			Stroke	No	Yes	
Son or Daughter 1.		a second and the second s	Epilepsy	No	Yes	
2.			Insanity	No	Yes	
3.			Suicide	No	Yes	
4.						

PERSONAL HISTORY

ILLNESSES: Have you ever had

Measles No Yes German Measles No Yes Mumps No Yes Chicken Pox No Yes Whooping Cough No Yes Whooping Cough No Yes Scarlet fever or Scarlatina No Yes Diphtheria No Yes Smallpox No Yes Pneumonia No Yes Pneumonia No Yes Pleurisy No Yes Rheumatic Fever or Heart Disease No Yes Arthritis or Rheumatism No Yes Any bone or joint disease No Yes Bursitis, Sciatica or Lumbago No Yes Polio or Meningitis No Yes Gonorrhea or Syphilis No Yes Jaundice No Yes Bladder disease No Yes Bladder disease No Yes Bladder disease No Yes Bladder disease No Yes Diabet	PLEASE ENCIRCLE ALL ANSWERS	No	Yes
Mumps No Yes Chicken Pox No Yes Whooping Cough No Yes Scarlet fever or Scarlatina No Yes Diphtheria No Yes Smallpox No Yes Pneumonia No Yes Influenza No Yes Pleurisy No Yes Rheumatic Fever or Heart Disease No Yes Arthritis or Rheumatism No Yes Any bone or joint disease No Yes Bursitis, Sciatica or Lumbago No Yes Polio or Meningitis No Yes Gonorrhea or Syphilis No Yes Jaundice No Yes Jaundice No Yes Bladder disease No Yes Bladder disease No Yes Migraine headaches No Yes Diabetes No Yes	Measles	No	Yes
Chicken Pox No Yes Whooping Cough No Yes Scarlet fever or Scarlatina No Yes Diphtheria No Yes Smallpox No Yes Smallpox No Yes Pneumonia No Yes Influenza No Yes Pleurisy No Yes Pleurisy No Yes Rheumatic Fever or Heart Disease No Yes Arthritis or Rheumatism No Yes Any bone or joint disease No Yes Bursitis, Sciatica or Lumbago No Yes Polio or Meningitis No Yes Gonorrhea or Syphilis No Yes Gallbladder disease No Yes Jaundice No Yes Bladder disease No Yes Epilepsy No Yes Diabetes No Yes	German Measles	No	Yes
Whooping Cough No Yes Scarlet fever or Scarlatina No Yes Diphtheria No Yes Smallpox No Yes Smallpox No Yes Pneumonia No Yes Influenza No Yes Pleurisy No Yes Rheumatic Fever or Heart Disease No Yes Any bone or joint disease No Yes Neuritis or Neuralgia No Yes Bursitis, Sciatica or Lumbago No Yes Polio or Meningitis No Yes Gonorrhea or Syphilis No Yes Gallbladder disease No Yes Jaundice No Yes Bladder disease No Yes Biladder disease No Yes Biladder disease No Yes Diabetes No Yes	Mumps	No	Yes
Scarlet fever or Scarlatina No Yes Diphtheria No Yes Smallpox No Yes Pneumonia No Yes Influenza No Yes Pleurisy No Yes Rheumatic Fever or Heart Disease No Yes Arthritis or Rheumatism No Yes Any bone or joint disease No Yes Bursitis, Sciatica or Lumbago No Yes Polio or Meningitis No Yes Gonorrhea or Syphilis No Yes Jaundice No Yes Bladder disease No Yes Bladder disease No Yes Bigraine headaches No Yes Diabetes No Yes	Chicken Pox	No	Yes
Diphtheria No Yes Smallpox No Yes Pneumonia No Yes Influenza No Yes Pleurisy No Yes Pleurisy No Yes Rheumatic Fever or Heart Disease No Yes Arthritis or Rheumatism No Yes Any bone or joint disease No Yes Bursitis, Sciatica or Lumbago No Yes Polio or Meningitis No Yes Gonorrhea or Syphilis No Yes Gallbladder disease No Yes Jaundice No Yes Bladder disease No Yes Bladder disease No Yes Epilepsy No Yes Migraine headaches No Yes Diabetes No Yes			Yes
SmallpoxNoYesPneumoniaNoYesInfluenzaNoYesPleurisyNoYesPleurisyNoYesRheumatic Fever or Heart DiseaseNoYesArthritis or RheumatismNoYesAny bone or joint diseaseNoYesNeuritis or NeuralgiaNoYesBursitis, Sciatica or LumbagoNoYesPolio or MeningitisNoYesGonorrhea or SyphilisNoYesGallbladder diseaseNoYesJaundiceNoYesBladder diseaseNoYesEpilepsyNoYesMigraine headachesNoYesDiabetesNoYes	Scarlet fever or Scarlatina	No	Yes
Pneumonia No Yes Influenza No Yes Pleurisy No Yes Rheumatic Fever or Heart Disease No Yes Arthritis or Rheumatism No Yes Any bone or joint disease No Yes Neuritis or Neuralgia No Yes Bursitis, Sciatica or Lumbago No Yes Polio or Meningitis No Yes Gonorrhea or Syphilis No Yes Gallbladder disease No Yes Jaundice No Yes Bladder disease No Yes Migraine headaches No Yes Tuberculosis No Yes Diabetes No Yes	Diphtheria	No	Yes
InfluenzaNoYesPleurisyNoYesRheumatic Fever or Heart DiseaseNoYesArthritis or RheumatismNoYesAny bone or joint diseaseNoYesNeuritis or NeuralgiaNoYesBursitis, Sciatica or LumbagoNoYesPolio or MeningitisNoYesGonorrhea or SyphilisNoYesGallbladder diseaseNoYesJaundiceNoYesBladder diseaseNoYesBladder diseaseNoYesDiabetesNoYesNoYesNoYesNoYesSolder diseaseNoYesStandiceNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYes	Smallpox	No	Yes
Pleurisy No Yes Rheumatic Fever or Heart Disease No Yes Arthritis or Rheumatism No Yes Any bone or joint disease No Yes Neuritis or Neuralgia No Yes Bursitis, Sciatica or Lumbago No Yes Polio or Meningitis No Yes Gonorrhea or Syphilis No Yes Gallbladder disease No Yes Jaundice No Yes Bladder disease No Yes Bladder disease No Yes Jaundice No Yes Migraine headaches No Yes Diabetes No Yes	Pneumonia	No	Yes
Rheumatic Fever or Heart Disease No Yes Arthritis or Rheumatism No Yes Any bone or joint disease No Yes Neuritis or Neuralgia No Yes Bursitis, Sciatica or Lumbago No Yes Polio or Meningitis No Yes Gonorrhea or Syphilis No Yes Gallbladder disease No Yes Jaundice No Yes Bladder disease No Yes Migraine headaches No Yes Diabetes No Yes	Influenza	No	Yes
Arthritis or Rheumatism No Yes Any bone or joint disease No Yes Neuritis or Neuralgia No Yes Bursitis, Sciatica or Lumbago No Yes Polio or Meningitis No Yes Rephritis No Yes Gonorrhea or Syphilis No Yes Gallbladder disease No Yes Jaundice No Yes Bladder disease No Yes Sidder disease No Yes Jaundice No Yes Bladder disease No Yes Diabetes No Yes	Pleurisy	No	Yes
Any bone or joint disease No Yes Neuritis or Neuralgia No Yes Bursitis, Sciatica or Lumbago No Yes Polio or Meningitis No Yes Gonorrhea or Syphilis No Yes Gallbladder disease No Yes Jaundice No Yes Bladder disease No Yes Bladder disease No Yes Diabetes No Yes	Rheumatic Fever or Heart Disease	No	Yes
Neuritis or Neuralgia No Yes Bursitis, Sciatica or Lumbago No Yes Polio or Meningitis No Yes Rephritis No Yes Gonorrhea or Syphilis No Yes Gallbladder disease No Yes Jaundice No Yes Bladder disease No Yes Bladder disease No Yes Bladder disease No Yes Diabetes No Yes	Arthritis or Rheumatism	No	Yes
Bursitis, Sciatica or Lumbago No Yes Polio or Meningitis No Yes Nephritis No Yes Gonorrhea or Syphilis No Yes Gallbladder disease No Yes Anemia No Yes Jaundice No Yes Bladder disease No Yes Bladder disease No Yes Migraine headaches No Yes Tuberculosis No Yes Diabetes No Yes	Any bone or joint disease	No	Yes
Polio or Meningitis No Yes Nephritis No Yes Gonorrhea or Syphilis No Yes Gallbladder disease No Yes Gallbladder disease No Yes Jaundice No Yes Bladder disease No Yes Bladder disease No Yes Epilepsy No Yes Migraine headaches No Yes Tuberculosis No Yes Diabetes No Yes	Neuritis or Neuralgia	No	Yes
Nephritis No Yes Gonorrhea or Syphilis No Yes Gallbladder disease No Yes Anemia No Yes Jaundice No Yes Bladder disease No Yes Epilepsy No Yes Migraine headaches No Yes Tuberculosis No Yes Diabetes No Yes	Bursitis, Sciatica or Lumbago	No	Yes
Gonorrhea or Syphilis No Yes Gallbladder disease No Yes Anemia No Yes Jaundice No Yes Bladder disease No Yes Bladder disease No Yes Epilepsy No Yes Migraine headaches No Yes Tuberculosis No Yes Diabetes No Yes	Polio or Meningitis	No	Yes
Gallbladder disease No Yes Anemia No Yes Jaundice No Yes Bladder disease No Yes Epilepsy No Yes Migraine headaches No Yes Tuberculosis No Yes Diabetes No Yes	Nephritis	No	Yes
Anemia No Yes Jaundice No Yes Bladder disease No Yes Epilepsy No Yes Migraine headaches No Yes Tuberculosis No Yes Diabetes No Yes	Gonorrhea or Syphilis	No	Yes
Jaundice No Yes Jaundice disease No Yes Bladder disease No Yes Epilepsy No Yes Migraine headaches No Yes Tuberculosis No Yes Diabetes No Yes	Gallbladder disease	No	Yes
Bladder disease No Yes Epilepsy No Yes Migraine headaches No Yes Tuberculosis No Yes Diabetes No Yes	Anemia	No	Yes
Epilepsy No Yes Migraine headaches No Yes Tuberculosis No Yes Diabetes No Yes	Jaundice	No	Yes
Migraine headaches No Yes Tuberculosis No Yes Diabetes No Yes	Bladder disease	No	Yes
Tuberculosis No Yes Diabetes No Yes	Epilepsy	No	Yes
Diabetes No Yes	Migraine headaches	No	Yes
	Tuberculosis	No	Yes
Cancer No Yes	Diabetes	No	Yes
	Cancer	No	Yes

High or low blood pressureNo Colitis or other bowel diseaseNo Hemorrhoids or any rectal diseaseNo Nervous BreakdownNo Food, chemical or drug poisoningNo Hay fever or AsthmaNo Hives or EczemaNo	
Hemorrhoids or any rectal disease No Nervous Breakdown No Food, chemical or drug poisoning No Hay fever or Asthma No	
Nervous Breakdown No Food, chemical or drug poisoning No Hay fever or Asthma No	
Food, chemical or drug poisoning No Hay fever or Asthma No	
Hay fever or Asthma No	
Hives or Eczema No	
Frequent infections or boils No	
AIDSNo	
Any other disease No	
ALLERGIES: Are you allergic to	
Penicillin or Sulfa No	
Aspirin, Codeine or Morphine No	
Mycins or other Antibiotics No	
Merthiolate or Mercurochrome No	
Any other drug No	
Any foods No	
Adhesive Tape No	
Nail polish or other cosmetics No	
Tetanus Antitoxin or Serums No	
INJURIES: Have you had any	
Broken or cracked bones No	
Sprains No	
Lacerations No	
Dislocations No	
Concussion, or head injury No	
Ever been knocked unconscious No	
WEIGHT: Now One Year Ago	
Maximum When	
TRANSFUSIONS: Have you ever had	
Blood or Plasma Transfusion No	

Yes Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Tonsillectomy		No	Yes
Appendectomy		No	Yes
Any other operation		No	Yes
Туре	Year		
Туре	_ Year_		
Туре	Year_		
Do you smoke		No	Ye
How many per day			
Have you ever been advised to have			
any surgical operation which has			
not been done		No	Ye
Have you been hospitalized for			
any illness		No	Ye
Give details:			

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Dizzness on change of position No Unconscious Spells No Dudie Vision No Double Vision No Stots before eyes No May change in vision No Any change in vision No Double Vision No May change in vision No Do you wear glasses No When were they last checked No Earaches No Discharge from Ears No Discharge from Ears No Decrease in hearing No Recurrent head colds No Sinus Trouble No Recurrent head colds No Strange persistent odors No Strange persistent odors No Strange taste or loss in taste No Persistent hoarseness No Difficulty swallowing No Screenes or bleding of gums on brushing No Coughed up blood No Caughed up blood No Coughed up blood No Chare fingers No	Frequent or severe headaches	No
Dizziess on change of positionNo Dizziess on change of positionNo Double VisionNo Double VisionNo Double VisionNo Double VisionNo Any change in visionNo Any change in visionNo Do you wear glassesNo Discharge from EarsNo Discharge from EarsNo Discharge from EarsNo Decrease in hearingNo Recurrent head coldsNo Strange parsitent odorsNo Difficulty swallowingNo No Descrease or loss in tasteNo Decrease or bleeding of gums on brushingNo Chest painNo Chest painNo Chest painNo Chest painNo Chest painNo Decrease or bleeding of gums on brushingNo Changina percisitent cough on thrushingNo Changina percisitent cough on thrushingNo Chone flight of stairsNo Chronic or frequent cough on thrushingNo Decrease of bleeding of gums on brushingNo Chronic or frequent cough on thing downNo Chronic or frequent cough on thing down	Fainting spells	No
Blurred Vision No Double Vision No Double Vision No Double Vision No Poin behind eyes No Any change in vision No Do you wear glasses No When were they last checked		
Blurred Vision No Double Vision No Double Vision No Double Vision No Poin behind eyes No Any change in vision No Do you wear glasses No When were they last checked		
Spots before eyes No Infacted eyes No Any change in vision No Any change in vision No Oboy ou warg glasses No When were they last checked No Earaches No Diccrease in hearing No Recurrent nose bleeds No Recurrent nose bleeds No Strange persistent odors No Strange persistent odors No Strange persistent odors No Recurrent sore throats No Recurrent sores in mouth No Coughed up blood No Caughed up blood No Coughed up blood No Coughed up blood No Chronic or frequent cough on hying down No No No Chronic or frequent cough on hying down No No No Chronic or frequent cough on hying down No Purple lips of fingers		
Spots before eyes No Infacted eyes No Any change in vision No Any change in vision No Oboy ou warg glasses No When were they last checked No Earaches No Diccrease in hearing No Recurrent nose bleeds No Recurrent nose bleeds No Strange persistent odors No Strange persistent odors No Strange persistent odors No Recurrent sore throats No Recurrent sores in mouth No Coughed up blood No Caughed up blood No Coughed up blood No Coughed up blood No Chronic or frequent cough on hying down No No No Chronic or frequent cough on hying down No No No Chronic or frequent cough on hying down No Purple lips of fingers	Double Vision	No
Pain behind eyes No Any change in vision No Moy change in vision No When were they last checked No Earaches No Discharge from Ears No Ringing in ears No Decrease in hearing No Recurrent head colds No Situs Trouble No Hay fever No Strange persistent odors No Strange persistent odors No Persistent hoarseness No Diffoulty swallowing No Recurrent sore throats No Recurrent sore in mouth No Soreness or bleeding of gums on brushing No Coughed up blood No Pain in arm(s) No No on flight indenss (lasting more than 3 weeks) No Chronic or frequent cough or throat clearing not associated with a known ilmess (lasting more than 3 weeks) No No No On hight down No Walking several blocks No Or no flight of stars No Shortness of breath		No
Any change in vision No Do you wear glasses No Discharge from Ears No Discharge from Ears No Ringing in ears No Decrease in hearing No Recurrent head colds No Sinus Trouble No Hay fever No Strange persistent odors No Strange taste or loss in taste No Persistent hoarseneess No Difficulty swallowing No Recurrent sores in mouth No Recurrent sores in mouth No Soreness or bleeding of gums on brushing No Chest pain No Angina pectoris No Coughed up blood No Port in arm(s) No No throat clearing not associated No Wake up a tripit short of breath No How many bed pillows do you use No Shortness of breath on: No Waking several blocks No On lying down No Pulpit libos of fugers No Port figers	Infected eyes	No
Do you wear glasses No When were they last checked	Pain behind eyes	No
Do you wear glasses No When were they last checked	Any change in vision	No
Earaches No Discharge from Ears No Discharge from Ears No Recurrent nose bleeds No Recurrent nose bleeds No Recurrent nose bleeds No Sinus Trouble No Sharge persistent odors No Strange persistent odors No Strange taste or loss in taste No Persistent hoarseness No Difficulty swallowing No Recurrent sore throats No Recurrent sores in mouth No Soreness or bleeding of gums on brushing No Chest pain No Angina pectoris No Couphed up blood No Pain in arm(s) No Nothylth swats No Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) No Waking several blocks No One flight of stairs No On lying down No Purble lips or fingers No Palpitations or filteting of heart No No		
Discharge from Ears No Ringing in ears No Decrease in hearing No Recurrent nose bleeds No Recurrent nose bleeds No Situs Trouble No Hay fever No Strange persistent odors No Strange tersistent odors No Strange tersistent odors No Persistent hoarseness No Persistent hoarseness No Recurrent sore throats No Recurrent sore throats No Recurrent sore in mouth No Soreness or bleeding of gums on brushing No Coughed up blood No Coughed up blood No Coughed up at night short of breath No No unave a persistent ough or throat clearing not associated with a known illness (lasting more than 3 weeks) No More flight of stairs No No One flight of stairs No On light of stairs No No On flight of stairs No Palpitations or fluctering of heart No No No Wat kind gever	When were they last checked	
Discharge from Ears No Ringing in ears No Decrease in hearing No Recurrent nose bleeds No Recurrent nose bleeds No Situs Trouble No Hay fever No Strange persistent odors No Strange tersistent odors No Strange tersistent odors No Persistent hoarseness No Persistent hoarseness No Recurrent sore throats No Recurrent sore throats No Recurrent sore in mouth No Soreness or bleeding of gums on brushing No Coughed up blood No Coughed up blood No Coughed up at night short of breath No No unave a persistent ough or throat clearing not associated with a known illness (lasting more than 3 weeks) No More flight of stairs No No One flight of stairs No On light of stairs No No On flight of stairs No Palpitations or fluctering of heart No No No Wat kind gever	Earaches	No
Ringing in ears No Decrease in hearing No Decrease in hearing No Recurrent head colds No Sinus Trouble No Recurrent head colds No Sinus Trouble No Strange persistent doors No Strange persistent doors No Strange taste or loss in taste No Persistent hoarseness No Difficulty swallowing No Recurrent sores in mouth No Recurrent sores in mouth No Screeness or bleeding of gums on brushing No Chest pain No Angina pectoris No Coughed up blood No Do you have a persistent cough or throat clearing not associated With a known liness (asting more than 3 weeks) No One flight of stairs No Chorein arm(s) No No Shortness of breath on: No Walking several blocks No On hying down No Purple lips or fingers No Purple lips or fingers No <tr< td=""><td></td><td>No</td></tr<>		No
Decrease in hearing No Recurrent hoad colds No Recurrent head colds No Sinus Trouble No Hay fever No Strange presistent codors No Strange taste or loss in taste No Persistent hoarseness No Difficulty swallowing No Enlarged glands No Recurrent sore throats No Recurrent sore throats No Recurrent sore throats No Recurrent sore throats No Coughed up blood No Coughed up blood No Coughed up blood No Pain in arm(s) No No group ave a persistent cough or throat clearing not associated No With a known illness (lasting more than 3 weeks) No No up ave a persistent cough or throat clearing not associated No Waking several blocks No On briging down No No De tight of stairs No No Electrons or fluttering of heart No Moding pessure No No dring down		
Recurrent nose bleeds No Recurrent head colds No Situas Trouble No Hay fever No Sitange persistent odors No Strange taste or loss in taste No Persistent hoarseness No Difficulty swallowing No Enlarged glands No Recurrent sores in mouth No Screness or bleeding of gums on brushing No Chest pain No Angina pectoris No Coughed up blood No Pain in arm(s) No No thave a persistent cough or throat clearing not associated No No up ave a persistent cough on lying down No No up ave a persistent or of breath No How many bed pillows do you use		
Sinus Trouble No Hay fever No Strange taste or loss in taste No Strange taste or loss in taste No Persistent hoarseness No Difficulty swallowing No Enlarged glands No Recurrent sore throats No Recurrent sore throats No Angina pectoris No Coughed up blood No Pain in arm(s) No No by out have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) No No Chronic or frequent cough on lying down No Wake up at night short of breath No How many bed pillows do you use		
Hay fever No Strange persistent odors No Strange taste or loss in taste No Persistent hoarseness No Difficulty swallowing No Enlarged glands No Recurrent sores in mouth No Screeness or bleeding of gums on brushing No Chest pain No Angina pectoris No Coughed up blood No Pain in arm(s) No Do you have a persistent cough or throat clearing not associated No With a known illness (lasting more than 3 weeks) No Do you have a persistent cough on lying down No Main tarm(s) No Wake up at night short of breath No How many bed pillows do you use	Recurrent head colds	No
Strange persistent odors No Strange taste or loss in taste No Persistent hoarseness No Difficulty swallowing No Enlarged glands No Recurrent sore throats No Recurrent sore throats No Soreness or bleeding of gums on brushing No Angina pectoris No Coughed up blood No Coughed up blood No Pain in arm(s) No No by out have a persistent cough or throat clearing not associated No With a known illness (lasting more than 3 weeks) No Ob you have a persistent cough on lying down No Wake up at night short of breath No How many bed pillows do you use	Sinus Trouble	No
Strange taste or loss in taste No Persistent hoarseness No Difficulty swallowing No Enlarged glands No Recurrent sore throats No Recurrent sore throats No Chest pain No Angina pectoris No Coughed up blood No Pain in arm(s) No Oughed up blood No Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) No Do you have a persistent cough on lying down No Wake up at night short of breath No How many bed pillows do you use	Hay fever	No
Persistent hoarseness No Difficulty swallowing No Enlarged glands No Recurrent sore tin mouth No Soreness or bleeding of guns on brushing No Chest pain No Angina pectoris No Coughed up blood No Pain in arm(s) No Nothit a known illness (lasting more than 3 weeks) No Do you have a persistent cough or throat clearing not associated No With a known illness (lasting more than 3 weeks) No Chronic or frequent cough on lying down No How many bed pillows do you use	Strange persistent odors	No
Persistent hoarseness No Difficulty swallowing No Enlarged glands No Recurrent sore tin mouth No Soreness or bleeding of guns on brushing No Chest pain No Angina pectoris No Coughed up blood No Pain in arm(s) No Nothit a known illness (lasting more than 3 weeks) No Do you have a persistent cough or throat clearing not associated No With a known illness (lasting more than 3 weeks) No Chronic or frequent cough on lying down No How many bed pillows do you use	Strange taste or loss in taste	No
Difficulty swallowing No Enlarged glands No Recurrent sores in mouth No Soreness or bleeding of gums on brushing No Angina pectoris No Coughed up blood No Angina pectoris No Coughed up blood No Pain in arm(s) No Night sweats No Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) No No Wake up at night short of breath No How many bed pillows do you use		
Enlarged glands No Recurrent sore throats No Recurrent sores in mouth No Soreness or bleeding of gums on brushing No Angina pectoris No Coughed up blood No Pain in arm(s) No Night sweats No Do you have a persistent cough or throat clearing not associated No With a known illness (lasting more than 3 weeks) No Do you have a persistent cough on lying down No How many bed pillows do you use		100000
Recurrent sore throats No Recurrent sores in mouth No Recurrent sores in mouth No Chest pain No Chest pain No Chest pain No Chest pain No Coughed up blood No Pain in arm(s) No No No Nothave a persistent cough or throat clearing not associated No With a known illness (lasting more than 3 weeks) No Chronic or frequent cough on lying down No Chronic or frequent cough on lying down No Chronic or frequent cough on lying down No How many bed pillows do you use	Enlarged glands	No
Recurrent sores in mouth No Soreness or bleeding of gums on brushing No Chest pain No Angina pectoris No Coughed up blood No Pain in arm(s) No Do you have a persistent cough or throat clearing not associated No With a known illness (lasting more than 3 weeks) No Chronic or frequent cough on lying down No Make up at night short of breath No How many bed pillows do you use		
Soreness or bleeding of gums on brushing No Angina pectoris No Angina pectoris No Coughed up blood No Pain in arm(s) No Night sweats No Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) No Chronic or frequent cough on lying down No No Chronics or frequent cough on lying down No How many bed pillows do you use		
Chest pain No Angina pectoris No Coughed up blood No Pain in arm(s) No Night sweats No Do you have a persistent cough or throat clearing not associated No With a known illness (lasting more than 3 weeks) No Chronic or frequent cough on lying down No Wak up at night short of breath No How many bed pillows do you use		
Angina pectoris No Coughed up blood No Pain in arm(s) No Do you have a persistent cough or throat clearing not associated No with a known illness (lasting more than 3 weeks) No Chronic or frequent cough on lying down No Wake up at night short of breath No How many bed pillows do you use		
Coughed up blood No Pain in arm(s) No Night sweats No Do you have a persistent cough or throat clearing not associated No With a known illness (lasting more than 3 weeks) No Chronic or frequent cough on lying down No Wake up at night short of breath No How many bed pillows do you use	·	
Night sweats No Do you have a persistent cough or throat clearing not associated No With a known illness (lasting more than 3 weeks) No Chronic or frequent cough on lying down No Wake up at night short of breath No How many bed pillows do you use	Coughed up blood	No
Do you have a persistent cough or throat clearing not associated No With a known illness (lasting more than 3 weeks) No Chronic or frequent cough on lying down No Wake up at night short of breath No How many bed pillows do you use	Pain in arm(s)	No
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	Night sweats	No
Chronic or frequent cough on lying down No Wake up at night short of breath No How many bed pillows do you use	Do you have a persistent cough or throat clearing not associated	
Chronic or frequent cough on lying down No Wake up at night short of breath No How many bed pillows do you use	with a known illness (lasting more than 3 weeks)	No
Wake up at night short of breath No How many bed pillows do you use		
Shortness of breath on: Walking several blocks		
Shortness of breath on: Walking several blocks	How many bed pillows do you use	
One flight of stairs No On lying down No Purple lips or fingers No Purple lips or fingers No Pligh blood pressure No Swelling of hands, feet or ankles No Swelling of hands, feet or ankles No Swelling of hands, feet or ankles No Start time of day	Shortness of breath on:	
One flight of stairs No On lying down No Purple lips or fingers No Purple lips or fingers No Pligh blood pressure No Swelling of hands, feet or ankles No Swelling of hands, feet or ankles No Swelling of hands, feet or ankles No Start time of day	Walking several blocks	No
On lying down No Purple lips or fingers No Palpitations or fluttering of heart No High blood pressure No Swelling of hands, feet or ankles No At what time of day		
Palpitations or fluttering of heart No High blood pressure No Swelling of hands, feet or ankles No At what time of day No Leg cramps on walking or at night No Enlarged veins in legs No Recurrent stomach pain No Belching or heartburn No Belching or heartburn No Relieved by food or medication No Appetite - Good Fair Poor Nausea or vomiting No Vomited blood No Avoid some foods No Woid spices No Avoid spices No Avoid spices No Avoid spices No Avoid spices No Rectal pain with bowel movement No Pain on urinating No Describe No Pain on urinating urination No Do you get up at night to urinate No Do you get up at night to urinate No How many times No Urinate less than before No <td< td=""><td>On lying down</td><td>No</td></td<>	On lying down	No
Palpitations or fluttering of heart No High blood pressure No Swelling of hands, feet or ankles No At what time of day No Leg cramps on walking or at night No Enlarged veins in legs No Recurrent stomach pain No Belching or heartburn No Recurrent stomach pain No Belching or heartburn No Relieved by food or medication No Nousea or vomiting No Novid some foods No What kinds No Avoid spices No Abdominal cramping No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No Pascribe Pain on urinating No Difficulty in starting urination No Difficulty in starting urination No Do you get up at night to urinate No How many times No Urinate less than before No How many times per day do you urinate No	Purple lips or fingers	No
High blood pressure No Swelling of hands, feet or ankles No At what time of day No Leg cramps on walking or at night No Enlarged veins in legs No Recurrent stomach pain No Belching or heartbum No Belching or heartbum No Relieved by food or medication No Appetite - Good Fair Poor Nausea or vomiting No Vornited blood No Avoid some foods No What kinds No Avoid spices No Abdominal cramping No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No Pain on urinating No Discribe No Pain on urinating No Dio you get up at night to urinate No Do you get up at night to urinate No How many times No Urinate less than before No How many times per day do you urinate No <td>Palpitations or fluttering of heart</td> <td>No</td>	Palpitations or fluttering of heart	No
At what time of day		
Leg cramps on walking or at night	Swelling of hands, feet or ankles	No
Enlarged veins in legs No Recurrent stomach pain No Belching or heartburn No Belching or heartburn No Believed by food or medication No Appetite - Good Fair Poor Nausea or vomiting No Vomited blood No Avoid some foods No What kinds No Avoid spices No Abdominal cramping No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times No Jrinate less than before No Any blood in urine No	At what time of day	
Enlarged veins in legs No Recurrent stomach pain No Belching or heartburn No Belching or heartburn No Believed by food or medication No Appetite - Good Fair Poor Nausea or vomiting No Vomited blood No Avoid some foods No What kinds No Avoid spices No Abdominal cramping No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times No Jrinate less than before No Any blood in urine No	Leg cramps on walking or at night	No
Recurrent stomach pain No Belching or heartburn No Belching or heartburn No Relieved by food or medication No Appetite - Good Fair Poor Nausea or vomiting No Noid some foods No Avoid some foods No What kinds No Avoid spices No Abdominal cramping No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No Pain on winating No Describe No Pain on winating No Do you get up at night to urinate No Do you get up at night to urinate No Jrinate more than before No Jrinate less than before No Any blood in urine No		
Belching or heartburn No Relieved by food or medication No Appetite - Good Fair Poor Nausea or vomiting No Nouride blood No Avoid some foods No What kinds No Avoid spices No Abdominal cramping No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: No Change in size, shape or texture of BM No Describe No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times No Jrinate less than before No Any blood in urine No		
Relieved by food or medication No Appetite - Good Fair Poor Nausea or vomiting No Vomited blood No Avoid some foods No What kinds No Avoid spices No Abdominal cramping No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: No Change in size, shape or texture of BM No Describe No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No Jrinate more than before No Jrinate less than before No Any blood in urine No		
Appetite - Good Fair Poor No Nausea or vomiting No Noid some foods No Avoid some foods No What kinds No Avoid spices No Avoid spices No Avoid spices No Abdominal cramping No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: No Change in size, shape or texture of BM No Describe No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times No Urinate less than before No Any blood in urine No How many times per day do you urinate No		
Nausea or vomiting No Vomited blood No Avoid some foods No What kinds No Avoid spices No Avoid spices No Abdominal cramping No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: No Change in size, shape or texture of BM No Describe No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times No Jrinate less than before No Any blood in urine No How many times per day do you urinate No		1
Vomited blood No Avoid some foods No What kinds No Avoid spices No Avoid spices No Abdominal cramping No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: No Change in size, shape or texture of BM No Describe No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times No Jrinate less than before No Any blood in urine No		No
Avoid some foods No What kinds No Avoid spices No Abdominal cramping No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: No Change in size, shape or texture of BM No Describe No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times No Jrinate less than before No Any blood in urine No		
What kinds No Avoid spices No Abdominal cramping No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: No Change in size, shape or texture of BM No Describe No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times Jrinate less than before No Jrinate less than before No Any blood in urine No No		
Avoid spices No Abdominal cramping No Color of bowel movement No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: No Change in size, shape or texture of BM No Describe No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times No Jrinate less than before No Any blood in urine No How many times per day do you urinate No		107
Abdominal cramping No Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: No Change in size, shape or texture of BM No Describe No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times Jrinate less than before No Jrinate less than before No Any blood in urine No		No
Color of bowel movement No Any blood in BM No Rectal pain with bowel movement No YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: No Change in size, shape or texture of BM No Describe No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times Jrinate less than before No Jrinate less than before No Any blood in urine No How many times per day do you urinate No		
Any blood in BM No Rectal pain with bowel movement No YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: No Change in size, shape or texture of BM No Describe No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times Jrinate less than before No Jrinate less than before No Any blood in urine No How many times per day do you urinate No		
Rectal pain with bowel movement No YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: No Change in size, shape or texture of BM No Describe No Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times Jrinate less than before No Jrinate less than before No Any blood in urine No How many times per day do you urinate No		No
YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: Change in size, shape or texture of BM		
Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times No Jrinate more than before No Jrinate less than before No Any blood in urine No How many times per day do you urinate No	YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR: Change in size, shape or texture of BM	No
Pain on urinating No Difficulty in starting urination No Do you get up at night to urinate No How many times No Jrinate more than before No Jrinate less than before No Any blood in urine No How many times per day do you urinate No	Describe	
Difficulty in starting urination No Do you get up at night to urinate No How many times No Jrinate more than before No Jrinate less than before No Any blood in urine No How many times per day do you urinate No		No
Do you get up at night to urinate No How many times No Urinate more than before No Urinate less than before No Any blood in urine No How many times per day do you urinate		
How many times No Urinate more than before No Jrinate less than before No Any blood in urine No How many times per day do you urinate No		
Urinate more than before No Urinate less than before No Any blood in urine No How many times per day do you urinate No		
Urinate less than before No Any blood in urine No How many times per day do you urinate		
Any blood in urine No How many times per day do you urinate		
How many times per day do you urinate		
	How many times per day do you urinate	
	Full feeling of bladder, but only small	
amount of urination No		Contra de contra

Lose urine on coughing or	sneezing			No	Yes
Discharge from penis	••••••••••••••••••••••••••••••••••••••			No	Yes
Recurrent back pains				No	Yes
Backaches				_ No	Yes
			18-588-		Yes
Swelling of any joints					Yes
Redness or heat of any join					Yes
Tingling or weakness of ha	nds or feet				Yes
Muscle Spasms			V		Yes
Loss or change in sensation					Yes
Trembling of any extremity Growth in neck or throat				_ No	Yes Yes
Hot flashes				No	Yes
Tiredness without apparent				No	Yes
Brittleness of nails				No	Yes
Dryness of skin				No	Yes
Easy bruising				No	Yes
Inability to stand heat				No	Yes
Inability to stand cold				_ No	Yes
Change in hair texture				_ No	Yes
Change in skin texture					Yes
Any skin rash				_ No	Yes
X-RAYS: Have you ever had x-				NI-	N/
Chest Stomach or colon				_ No No	Yes Yes
Gall bladder				1.020 MD0	Yes
Extremities				No	Yes
Back				No	Yes
Teeth				- Workshine	Yes
Other				No	Yes
EKG: Ever had an electrocardie	ogram?			No	Yes
IMMUNIZATIONS: Have you h	ad				
Smallpox vaccination					Yes
Tetanus shots (not ant	titoxin which la	ists only 2 week	<s)< td=""><td>No</td><td>Yes</td></s)<>	No	Yes
Polio shots within last	2 years	1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 -	000-10	_ No	Yes
DRUGS: Laxatives;	never 🗆	occ. 🗆	freq. 🗆	dai	ly 🗆
Vitamins;	never 🗆	occ. 🗆	freq. 🗆	dai	ly 🗆
Sedatives;	never 🗌	occ. 🗆	freq. 🗖	dai	ly 🗆
Tranquilizers;	never 🗆	occ. 🗆	freq. 🗆		ly 🗆
Sleeping pills, etc.;	never 🗆	occ. 🗆	freq. 🗆		ly 🗆
Aspirin, etc.;	never 🗌	occ. 🗆	freq. 🗌		ly 🗆
Cortisone, ACTH; Thyroid;	never 🗌 never 🗌		freq. 🗆	dai	ly 🗆
Thyroid,	daily		t, none now □ gr. day		
Appetite depressants	never 🗌		freq. 🗆	dai	ly 🗆
En la construction de la			noq. 🗅		50
Have you ever been treated Have you ever taken insulir				_ No	
Have you ever taken hormo					Yes Yes
Have you ever taken Fen-P					Yes
SEX: Entirely satisfactory?					Yes
WOMEN ONLY - MENSTRUA				0.000	
Age at onset					
Regular? 🗆 Yes 🛛	No 🗆	Varies			
Cycle days		A			
Flow: Heavy					
Number of pads used per p					
Any clots passed					Yes
Pains or cramps				_ NO	Yes
Date of last period Date of last pelvic exam				-	
Date of last Pap Test				-	
Results: Neg.			Act.		
Any discharge from vagina				No	Yes
If so, color					
amount				_	
Any itching of vaginal area				-	Yes
Do you take birth control pil				No	Yes
الملايين منتمط محما بينما ا			89-1 XII 01000	_	
How long have you tak	ken them	1000 TO 1000 TO 1000			
Pregnancies:					
Pregnancies: How many children bo	rn alive			_	
Pregnancies: How many children bo How many still births_	rn alive			-	
Pregnancies: How many children bo How many still births_ How many premature	rn alive		4	-	
Pregnancies: How many children bo How many still births_ How many premature How many Cesarean S	rn alive births Sections			-	
Pregnancies: How many children bo How many still births_ How many premature How many Cesarean S How many miscarriages	rn alive births Sections		4	-	Yes
Pregnancies: How many children bo How many still births_ How many premature How many Cesarean S	rn alive births Sections gnancy			-	Yes