

MI .....Yes No  
 Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Today's Date: \_\_\_\_\_

Tuberculosis ..... Yes No  
 Arthritis ..... Yes No  
 Cancer ..... Yes No  
 Kidney disease ..... Yes No  
 Asthma ..... Yes No  
 Allergies ..... Yes No  
 Ulcers ..... Yes No  
 Epilepsy ..... Yes No  
 Anemia ..... Yes No  
 Glaucoma ..... Yes No  
 Nervous breakdown ..... Yes No  
 Mental retardation ..... Yes No  
 Birth defects ..... Yes No  
 Thyroid problems ..... Yes No

**SECONDARY PREVENTION**

**Vaccinations:**

Date of last tetanus \_\_\_\_\_  
 Date of last Pneumovax \_\_\_\_\_  
 Date of last influenza vaccination \_\_\_\_\_  
 When have you taken the Hepatitis B vaccination \_\_\_\_\_  
 Have you ever had positive PPD/skin test for TB? .....Yes No  
 Have you had German Measles (Rubella)? Yes No If yes when \_\_\_\_\_  
 If not have you been vaccinated? Yes No If so, When \_\_\_\_\_  
 Date of last PPD/skin test for TB \_\_\_\_\_  
 Last visit regular eye care \_\_\_\_\_  
 Last visit dental care \_\_\_\_\_  
 Do you perform regular self-breast exams? .....Yes No  
 Do you have regular blood pressures checks? .....Yes No  
 Have you completed high school or received GED? ..... Yes No  
 Do you have a hobby? .....Yes No

The following questions apply to RECENT and what you believe are SIGNIFICANT symptoms.

Yes                      No

_____	_____	GENERAL
_____	_____	Recent weight change
_____	_____	Change in appetite
_____	_____	Fever or chills or night sweats
_____	_____	Fatigue (wear out easily)
_____	_____	Weakness (too weak to open jars, comb hair)
_____	_____	Tiredness (tired all the time)