215 W. Locust St. Fairbury, IL 6173
Ph. 815-692-2270 Fax 815-692-2280

Circle YES or NO…
Have you or any immediate family member everbeen told you have:

	Self	Family
Cancer	Yes No	Yes No
Diabetes	Yes No	Yes No
High blood pressure	Yes No	Yes No
Heart disease	YesNo	Yes No
Angina/chest pain	YesNo	Yes No
Stroke	Yes No	Yes No
Osteoporosis	Yes No	Yes No
Osteoarthritis	Yes No	Yes No
Rheumatoid arthritis	YesNo	Yes No
Head/Neck Trauma	Yes No	Yes No

In the past 3 months have you had or do youexperience:

A change in your health	YesNo
Nausea/Vomiting	YesNo
Fever/chills/sweats	YesNo
Unexplained weight loss	YesNo
Numbness or tingling	YesNo
Changes in appetite	YesNo
Difficulty swallowing	YesNo
Changes in bowel or bladder function	YesNo
Shortness of breath	Yes No
Dizziness	YesNo
Upper respiratory infection	YesNo
Urinary tract infection	Yes No

In the past year have you had 2 weeks or more during which you felt sad, blue, depressed or when you lost all interest in things that you usually cared about or enjoyed? YesNo

Have you felt sad or depressed much of the time in the past year? YesNo

Have you had any trauma to your head and neck (i.e.blunt trauma, fall, ejection from auto etc.)? Yes No

Do you have a history of:

Allergies/Asthma	Yes No
Headaches	Yes No
Bronchitis	Yes No
Kidney disease	YesNo
Rheumatic fever	YesNo
Ulcers	YesNo
Sexually Transmitted Disease	Yes No
Seizures	Yes No

Are you currently:

Pregnant	YesNo
Under Stress	YesNo

When did your symptoms begin?
_____

Are your symptoms: (circle one)
Getting Worse Same Improving

Do you have a problem with … (check all that apply)
Hearing Vision
Speech Communication

Do you or have you in the past smoked tobacco?
Yes No
If yes, _____ packs **X** _____years.
Last tobacco use _____

Do you drink alcoholic beverages?
Yes No
If yes, how many drinks do you routinely have per week? _____/week.

Date of last physical examination
_____

List medications currently using:_____