

**De Wester Comprehensive Evaluation Form- New Patient  
Part I (DCEF-NP I) ©**

Please fill out the whole form; this is *essential* for performing a thorough evaluation. You may circle NONE for sections that you have no information to share (please use blue ink when possible)

**Demographical information:** Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referred by: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Race/ethnicity (circle all that apply; add country if known):

|                         |                               |                           |
|-------------------------|-------------------------------|---------------------------|
| African American _____  | Indian (India) American _____ | Persian American _____    |
| Arab American _____     | Jewish American _____         | Polynesian American _____ |
| Asian American _____    | Latin American _____          | Turkish American _____    |
| European American _____ | Native American _____         | Other _____               |

Religion (optional - circle):

|                 |          |           |             |                                   |              |         |
|-----------------|----------|-----------|-------------|-----------------------------------|--------------|---------|
| Agnostic        | Hinduism | Atheistic | Buddhist    | Christian                         | Confucianism | Islamic |
| Native American | Taoism   | Sikhism   | Other _____ | Denominational branch/sect: _____ |              |         |

At DTRC we specialize in treatment of Sex Hormone related health concerns, including those complicated by a number of common medical problems. Indicate any of the additional health concerns listed below that you would like us to assist you with while we're addressing your sex hormones:

|   |   |  |
|---|---|--|
| <input type="checkbox"/> Migraine Headaches                             | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> weakness, fatigue, loss of muscle related to recent surgery, trauma, or other chronic medical disease |
| <input type="checkbox"/> Diabetes/diabetes prevention                   | <input type="checkbox"/> Chronic fatigue    | <input type="checkbox"/> Chronic Pain (in partnership with your Pain Specialist)   |
| <input type="checkbox"/> Weight loss/body composition treatment         | <input type="checkbox"/> Depression/anxiety |  |
| <input type="checkbox"/> Cardiovascular disease (heart disease, stroke) | <input type="checkbox"/> Metabolic syndrome |  |
| <input type="checkbox"/> Preventative Medicine                          | <input type="checkbox"/> Sexual Function    |  |
| <input type="checkbox"/> Other _____                                    |   |  |

Physician Use Only/HPI: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Do you desire that we send updates to your: PCP? Yes/ No Other Physician? Yes / No If yes, then please list contact information below and sign this consent. I authorize Jeffrey N De Wester MD to communicate freely concerning my health care with: \_\_\_\_\_ Signed; \_\_\_\_\_ date: \_\_\_\_/\_\_\_\_/\_\_\_\_**  
**I understand that my data will be used for research purposes by JNDTRC, but my identity will be protected by withholding identifying information. Any utilization of my medical information that will involve possible disclosure of my identity will be done only with my prior written consent, signed: \_\_\_\_\_ date: \_\_\_\_/\_\_\_\_/\_\_\_\_**  
**As a teaching institution I understand medical science students may be participating in my care, signed: \_\_\_\_\_ date: \_\_\_\_/\_\_\_\_/\_\_\_\_**

**Medication History/Substance Abuse History:**

Drug Allergies: \_\_\_\_\_

**Current prescription/over the counter medications as prescribed ( including vitamins and supplements ):**

| <u>Drug or Medication</u> | <u>Dosage/Frequency/date started</u> | <u>Condition</u> | <u>Effectiveness, side effects (if any)</u> |
|---------------------------|--------------------------------------|------------------|---|
| (e.g. Prozac              | 20 mg. a day/2002                    | depression       | still some depression, can't orgasm)        |
| _____                     | _____                                | _____            | _____                                       |
| _____                     | _____                                | _____            | _____                                       |
| _____                     | _____                                | _____            | _____                                       |
| _____                     | _____                                | _____            | _____                                       |
| _____                     | _____                                | _____            | _____                                       |
| _____                     | _____                                | _____            | _____                                       |

(See other side if more space required)

MD / NP / PA initials: \_\_\_\_\_

| Medication | Dosage/Frequency/date started | Condition | Effectiveness, side effects (if any) |
|------------|-------------------------------|-----------|--------------------------------------|
| _____      | _____                         | _____     | _____                                |
| _____      | _____                         | _____     | _____                                |
| _____      | _____                         | _____     | _____                                |
| _____      | _____                         | _____     | _____                                |
| _____      | _____                         | _____     | _____                                |
| _____      | _____                         | _____     | _____                                |

Are you taking medications as prescribed?:            Y            N  
 If no, comment: \_\_\_\_\_

**Symptom Review** (circle any significant symptoms you have experienced in the last 3 months and place an N in the box following the circled symptom if it started in the last 6 months, place a C in the box if you have had it longer than six months; place an L after the circled symptom if you have experienced these for years or since childhood.)

**Body Comp/General:** Weight loss [ ] Weight gain [ ] Fatigue [ ] Excessive energy [ ] Increased central/abdominal fat [ ]  
 Appetite changes [ ] Loss of breast volume/loss of female--"hour glass figure" [ ] "Man breasts" [ ] Poor response to diet/exercise for weight loss [ ]

**Skin:** Increased: looseness / wrinkling [ ] Dry / oily [ ] Changes in hair / nails [ ] Loss of: scalp/body hair [ ]

**Head/neck: Chronic or Recurring:** Sinus Pressure or pain [ ] Post Nasal Drip [ ] Sore, scratchy throat [ ] Recurring sinusitis [ ] Swollen glands [ ] Nasal stuffiness [ ] Runny nose, Sneezing, Itching eyes/ears [ ]

**Respiratory:** Cough [ ] Wheezing [ ] Asthma [ ] Bronchitis [ ] Pneumonia [ ] Snoring [ ]  
 Shortness of breath [ ]

**Cardiac:** Chest pain: with exertion / without exertion [ ] irregular heart beat or palpitations [ ] swelling: hands feet [ ]

**Urinary:** Increased need to urinate [ ] Sudden urge to urinate [ ] Pain on urination [ ]  
 Uncontrolled loss of urine [ ] Slowing of the urinary stream [ ] Increased nighttime urination [ ]  
 Pain in the testicles [ ]

**GYN:** Irregular periods [ ] PMS [ ] Pelvic Pain [ ] Menstrual cramps [ ] Vaginal dryness [ ]  
 Vaginal discharge [ ] Hot flashes [ ] Breast tenderness [ ] Pain with intercourse [ ]  
 Have you had any unplanned vaginal bleeding in the last year or since your last visit? YES / NO If so, how many episodes, how long did they last, and how heavy was the flow? \_\_\_\_\_

**Sexual function: Problems with:** Achieving and/or sustaining erections [ ] Premature ejaculation [ ] Loss of sex drive [ ]  
 Difficulty achieving orgasm [ ] Decreased intensity of orgasm [ ] Troubling sexual thoughts/desires [ ] Pain with intercourse [ ] Difficulty achieving clitoral engorgement and/or becoming aroused [ ]

**Musculoskeletal:** Muscle / joint: pains swelling stiffness [ ] Worsening arthritis pain [ ]  
 Joints affected: wrists elbows shoulders knees hips spine feet  
 Loss of muscle mass, tone, or strength [ ]

**Neurologic:** Numbness burning, or electrical pain [ ] Location: \_\_\_\_\_ Memory loss [ ]  
**Headaches or history of Migraines [ ] (circle all that apply):** Age of onset \_\_\_\_\_ Have your headaches deteriorated recently? Yes / NO Aggravated by - light / sound Associated with: nausea vomiting throbbing  
 Number of headaches per month: \_\_\_\_\_ Headaches associated with or preceded by: visual disturbance Numbness and/or weakness on one side of my body? YES / NO If so, where? \_\_\_\_\_  
 My Headaches are worse: with menstrual cycles on birth control with menopause hormone treatment wine hypoglycemia sleep deprivation certain medications: \_\_\_\_\_

**Hematologic:** Anemia [ ] Unexplained easy bleeding/bruising [ ] History of blood clots / embolus [ ]  
**CNS/Psych:** Depression [ ] Anxiety [ ] Panic attacks [ ] Mood swings [ ] irritability [ ] Manic episodes [ ]  
 Low motivation [ ] Memory loss [ ] Difficulty concentrating and/or staying on task [ ] Worsening job performance [ ] Binge eating [ ] Anorexia [ ] Bulimia [ ] Hallucinations [ ] Racing thoughts [ ]  
 Crying spells [ ] compulsions [ ] obsessions [ ] Antidepressants aren't effective or have lost effectiveness [ ]  
 My mood and/or anxiety are aggravated by(circle): my menstrual cycles hormone treatment birth control treatment menopause [ ]

**Sleep:** Sleep problems -- Getting to sleep Staying asleep waking up early [ ] Restless legs/arms before sleep [ ]  
 Snoring [ ] Pauses in breathing [ ] Going for days without need of sleep [ ] Jerking/kicking in sleep [ ]  
 Average number of hours a night you sleep \_\_\_\_\_ hrs/night

Elaborate on any of the above if needed: \_\_\_\_\_

Physician use: \_\_\_\_\_



**Past or Ongoing Illnesses and Medical Problems: NONE**

Check all for which you have been diagnosed and treated: Circle any you suspect you suffer from.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> allergies                     | <input type="checkbox"/> emphysema/chronic bronchitis                 | <input type="checkbox"/> osteoporosis                     |
| <input type="checkbox"/> arthritis, type _____         | <input type="checkbox"/> heart attack, MI; date _____                 | <input type="checkbox"/> pneumonia                        |
| <input type="checkbox"/> asthma                        | <input type="checkbox"/> heart disease                                | <input type="checkbox"/> psoriasis/seborrhea              |
| <input type="checkbox"/> bleeding disorder; Excessive  | <input type="checkbox"/> high blood pressure                          | <input type="checkbox"/> reflux esophagitis               |
| <input type="checkbox"/> bleeding after surgery/injury | <input type="checkbox"/> high cholesterol                             | <input type="checkbox"/> restless legs                    |
| <input type="checkbox"/> blood clots _____             | <input type="checkbox"/> hyperthyroidism                              | <input type="checkbox"/> seizures, type _____             |
| <input type="checkbox"/> bowel obstruction             | <input type="checkbox"/> hypoglycemia                                 | <input type="checkbox"/> sinusitis (chronic)              |
| <input type="checkbox"/> cancer, type _____            | <input type="checkbox"/> hypothyroidism                               | <input type="checkbox"/> sleep apnea                      |
| <input type="checkbox"/> colitis, type _____           | <input type="checkbox"/> indigestion or ulcers from anti-inflammatory | <input type="checkbox"/> stroke, date _____               |
| <input type="checkbox"/> degenerative disc disease:    | <input type="checkbox"/> medications _____                            | <input type="checkbox"/> testicular injury/disease: _____ |
| <input type="checkbox"/> site _____                    | <input type="checkbox"/> irritable bowel disease                      | _____   |
| <input type="checkbox"/> diabetes, type _____          | <input type="checkbox"/> kidney disease/stones                        | <input type="checkbox"/> tuberculosis                     |
| <input type="checkbox"/> eating disorder _____         | <input type="checkbox"/> migraine headaches                           | <input type="checkbox"/> other _____                      |
| <input type="checkbox"/> elevated blood sugar          | <input type="checkbox"/> narcolepsy                                   | _____   |
| <input type="checkbox"/> in pregnancy                  | <input type="checkbox"/> obesity/weight problems                      | _____   |

Physician Use: \_\_\_\_\_

**Preventative Medicine Screening Tests (date of last test, list any/abnormal findings): NONE**

- |                                  |                             |  |
|----------------------------------|-----------------------------|--|
| Physical exam: _____             | Colonoscopy: _____          | Spirometry: _____                        |
| Bone density: _____              | EKG: _____                  | Testosterone/<br>estradiol levels: _____ |
| Carotid/aortic ultrasound: _____ | Mammogram: _____            | Treadmill/<br>stress echo: _____         |
| CBC (blood count): _____         | Pap smear: _____            | TSH (thyroid): _____                     |
| Chest X-ray: _____               | PSA screening: _____        | _____                                    |
| Cholesterol/lipids: _____        | Rectal/prostate exam: _____ | _____                                    |
| Coronary Calcium CT: _____       | Other: _____                | _____                                    |

Are copies of past labs/tests \_\_\_\_\_ here? \_\_\_\_\_ available?

- |                                       |   |   |
|---------------------------------------|---|---|
| Perform self ABCD mole exam?          | Y | N |
| Perform monthly self breast exam?     | Y | N |
| Perform monthly self testicular exam? | Y | N |

**Past Surgeries/Procedures:(when appropriate list reason/diagnosis for the procedure, date, and any abnormal findings) NONE**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> adenoids/tonsils _____         | <input type="checkbox"/> gall bladder removal          | <input type="checkbox"/> prostatectomy/ TURP _____           |
| <input type="checkbox"/> appendectomy                   | <input type="checkbox"/> gastroscopy _____             | <input type="checkbox"/> sleep study, year/result: _____     |
| <input type="checkbox"/> biopsies: organ _____          | <input type="checkbox"/> hysterectomy _____            | <input type="checkbox"/> sinus surgery _____                 |
| <input type="checkbox"/> breast implants                | <input type="checkbox"/> infertility procedures _____  | <input type="checkbox"/> testicular surgery _____            |
| <input type="checkbox"/> cancer treatment, _____        | <input type="checkbox"/> joint replacement;            | <input type="checkbox"/> treadmill stress test _____         |
| <input type="checkbox"/> cardiac cath _____             | <input type="checkbox"/> location _____                | <input type="checkbox"/> ultrasound, site _____              |
| <input type="checkbox"/> coronary stent / balloon _____ | <input type="checkbox"/> laparoscopy for treatment of: | <input type="checkbox"/> History of previous prostate biopsy |
| <input type="checkbox"/> colposcopy                     | <input type="checkbox"/> adhesions                     | <input type="checkbox"/> If so, list result: _____           |
| <input type="checkbox"/> colonoscopy _____              | <input type="checkbox"/> endometriosis                 | _____  |
| <input type="checkbox"/> coronary bypass grafts         | <input type="checkbox"/> ovarian cysts _____           | <input type="checkbox"/> Other surgeries: _____              |
| <input type="checkbox"/> echocardiogram                 | <input type="checkbox"/> ovaries removed               | _____  |

**Vaccines previously received: NONE: \_\_\_\_\_ ever \_\_\_\_\_ since last preventative exam at DTRC \_\_\_\_\_ since my first visit to DTRC**  
(list approximate date received when possible)

- |   |  |  |   |  |
|---|--|--|---|--|
| <input type="checkbox"/> flu ____/____/____     | <input type="checkbox"/> H1N1 ____/____/____ | <input type="checkbox"/> flu/H1N1 ____/____/____ | <input type="checkbox"/> pneumonia ____/____/____ | <input type="checkbox"/> Shingles ____/____/____ |
| <input type="checkbox"/> tetanus ____/____/____ |  |  |   |  |

MD / NP / PA initials: \_\_\_\_\_

**Psychiatric History:** NONE

Check those diagnoses given by a doctor: Place an X by any condition you think you may suffer from.

Past diagnosis of:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> ADD/ADHD                              | <input type="checkbox"/> OCD (obsessive compulsive disorder) | <input type="checkbox"/> PTSD                                     |
| <input type="checkbox"/> alcoholism/substance abuse            | <input type="checkbox"/> panic attacks/disorder              | <input type="checkbox"/> schizophrenia                            |
| <input type="checkbox"/> anxiety; generalized anxiety disorder | <input type="checkbox"/> physical, emotional or sexual abuse | <input type="checkbox"/> social anxiety (SAD)/performance anxiety |
| <input type="checkbox"/> bipolar/manic depressive illness      | <input type="checkbox"/> PMS                                 | <input type="checkbox"/> suicide attempts                         |
| <input type="checkbox"/> bulimia/anorexia                      | <input type="checkbox"/> postpartum depression               | <input type="checkbox"/> other: _____                             |
| <input type="checkbox"/> depression; number of episodes _____  |  |   |

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**Sex Hormone influence:** Have sex hormones or sex hormone treatment ever caused depression and/or anxiety symptoms or caused such symptoms to deteriorate ( ie increased mood swings around your menstrual cycle) ? Yes / No

If yes, were these symptoms ever treated with sex hormones( ie taking a birth control pill to treat PMS)? Yes / No

If yes, what treatment was prescribed and describe your reaction to the treatment \_\_\_\_\_

**If you have experienced deterioration of mood or anxiety symptoms from sex hormone influence, did the deterioration of your symptoms occur while you were already on on treatment with antidepressants? Yes / No**

**Please circle any circumstances that are or were associated with deterioration of your anxiety or mood symptoms:** menstrual cycles irregular periods, postpartum (within 3 months of giving birth), around or during menopause, infertility treatment, treatment with hormones (ie Birth control pills, Depo-Progesterone, infertility treatment, HRT, etc), after hysterectomy

Inpatient Psychiatric/Chemical Dependency Hospitalizations (Include place and date)

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Any prior or current Outpatient Counseling? Y N If currently in currently in counseling, by whom and through what institution?

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Physician use: \_\_\_\_\_

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MD / NP / PA initials: \_\_\_\_\_

**Hormonal/Fertility History (the portion of this section in red is mandatory for both men and women, black for women only):**

What was the first day of your last menstrual period: \_\_\_/\_\_\_/\_\_\_ If menopausal, when did you begin menopause? \_\_\_/\_\_\_/\_\_\_

How often do your periods occur?: every \_\_\_ days Duration of menses: \_\_\_ days Age menses began: \_\_\_

Have you even had an abnormal PAP? (list diagnosis if known) \_\_\_\_\_

# of pregnancies: \_\_\_ # of births: \_\_\_ # of miscarriages/abortions: \_\_\_

# of vaginal deliveries: \_\_\_ # of cesarean sections: \_\_\_ Any history of infertility? Y N

Have you undergone a hysterectomy? Yes / No Were one or both of your ovaries removed? Yes / No

Is it currently possible for you and your mate to conceive? Y N If not, please circle reason? Hysterectomy vasectomy menopausal using contraception infertility Other: \_\_\_\_\_

If yes, are you currently trying to conceive? Y N

If not, what form of contraceptive measures are you (or spouse) taking (circle)? Pill? Condom? IUD? Diaphragm?

Depoprogestosterone? Other? \_\_\_\_\_

If you've ever taken "the pill" estimate the number of yrs of total use: \_\_\_ yrs

List as many as you can remember of the hormone pills/vaginal rings/patches/shots/implants etc. with which you've been previously treated with for contraception (pre menopause)

| Name  | Type (i.e. pill, shot, implant, etc) | When utilized/how long used |
|-------|--------------------------------------|-----------------------------|
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |

Have you previously been treated with hormone replacement therapy for menopause (HRT)? Yes / No

If yes, how long after you began experiencing menopausal symptoms (or surgical removal of both ovaries) did you begin HRT? \_\_\_ yrs. Since starting HRT has it ever been stopped? Yes / No If yes, how many yrs were you off HRT? \_\_\_ yrs

List as many as you can remember of the different HRT hormone products with which you've been previously treated:

| Name  | Type (i.e. pill, shot, implant, etc) | When utilized/how long used |
|-------|--------------------------------------|-----------------------------|
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |
| _____ | _____                                | _____                       |

MD / NP / PA initials: \_\_\_\_\_

**Sexual History:**

Have you ever been sexually active? Y N Are you presently sexually active? Y N Are you sexually active with anyone other than your spouse / mate? Y N Please Circle your sexual orientation: heterosexual bisexual gay / lesbian uncertain  
 Do you have any significant questions about what constitutes healthy sexual behavior that you would like addresses? Y N  
 How many sexual partners have you had? \_\_\_\_\_ Have you ever had unprotected sex? Y N  
 Has a low sex drive and/or achieving sexual satisfaction/orgasm been a long term problem for you? Y N  
 History of **sexual abuse / rape**? Y N Any other form of **abuse**? Y N Do you think that **marital / relationship stress** is contributing to the sexual problems in your relationship? Y N  
 If so, have you discussed your **abuse / relationship stress** in therapy or with a health professional? Y N  
 Have you ever had a sexually transmitted disease? Y N If yes, what type: \_\_\_\_\_  
 Additional comments: \_\_\_\_\_

Physician use: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Social History:**

Marital Status: S M D #of children \_\_\_\_\_ Education Level: HS/College/Grad./Profession \_\_\_\_\_  
 Employment: \_\_\_\_\_

Stressors: (Check all that apply; elaborate as needed)

- buying/moving/building house
- occupational uncertainty/stress
- relationships: death, separation, divorce
- cultural/racial
- family members' health or other stressors
- school hours/performance
- financial
- other: \_\_\_\_\_

**Diet/Exercise History:**

Circle the choice that best describes your current diet: Regular "see food" kosher low fat low cal high fat/high carb  
 vegetarian Wt Watchers Low Carb – Atkins / South Beach other: \_\_\_\_\_  
 List the diets you've tried in the past and the results you've had with them: \_\_\_\_\_

Type of exercise: NONE Running Jogging Walking Biking Swimming Aerobics  
 Weight lifting Pilates Yoga \_\_\_\_\_ times per week

**Family History:**(List all biologic immediate family, parents, grandparents, aunts, uncles, with the condition.)

Unavailable  NONE KNOWN

**Family Psychiatric History**

**NONE KNOWN**

|                           | Mthr | Fthr | Sib(1) | Sib(2) | Sib(3) | Gfthr | Gmthr | Uncle | Aunt | Other |
|---------------------------|------|------|--------|--------|--------|-------|-------|-------|------|-------|
| ADD/ADHD                  | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Alcohol/drug abuse        | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Anxiety/panic             | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Bipolar                   | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Depression                | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| OCD                       | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| SAD                       | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Psych hospitalization     | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Suicide/suicide attempts* | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |

**Physician use:**

\*(circle Suicide if attempt was successful)

(List all biologic immediate family, parents, grandparents, aunts, uncles, with the condition.)

\_\_\_ Unavailable \_\_\_ NONE KNOWN

| <b>General Medical:</b>         | Mthr | Fthr | Sib(1) | Sib(2) | Sib(3) | Gfthr | Gmthr | Uncle | Aunt | Other |
|---------------------------------|------|------|--------|--------|--------|-------|-------|-------|------|-------|
| Allergies (i.e. hay fever)      | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Aneurism                        | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Aortic                          | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Brain                           | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Asthma                          | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Arthritis (Rheumatoid)          | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| <b>Cancer/Tumors :</b>          |      |      |        |        |        |       |       |       |      |       |
| Brain                           | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Bladder                         | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Breast                          | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Cervical                        | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Esophageal /Gastric             | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Kidney                          | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Laryngeal (throat)              | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Lymphoma / Leukemia             | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Lung                            | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Ovarian / Testicular            | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Pancreatic / Colon              | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Skin / Melanoma                 | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Thyroid                         | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Uterine / Prostate              | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Other:                          | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Clotting Disorder               | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Dementia (Alzheimer's)          | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Diabetes (adult onset)          | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Early menopause (before age 44) | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Emphysema                       | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Heart birth defects             | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Heart disease/heart attack*     | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Hemachromatosis (excess iron)   | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| High blood pressure             | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| High cholesterol                | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Migraines                       | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Obesity                         | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Osteoporosis                    | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Stroke                          | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |
| Thyroid disese                  | [ ]  | [ ]  | [ ]    | [ ]    | [ ]    | [ ]   | [ ]   | [ ]   | [ ]  | [ ]   |

\*includes anyone who has undergone: bypass surgery, stent placement, or balloon angioplasty

Physician use: \_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MD / NP / PA initials: \_\_\_\_\_