

Name _____ *Richard Douglas Iliff, MD* Date ___/___/___

Database History Age _____

Highest education level achieved: _____ Present occupation: _____

Lifestyle Physiologic Age You may be 60 going on 77, or 60 going on 48. I want to know which. If you are over 30 years of age, go to realigne.com and take their test. Then enter the results here: My chronological age is _____. My RealAge is _____.

Functional Physiologic Age I want you to walk a mile as fast as you can, and record the results. Don't do it if you have any reason to think you have heart disease. In that case, we'll do a treadmill at your physical. You must walk outside, on a track or measured course (walkjogrun.net will enable you to measure a mile in your neighborhood). Or you can walk the Iliff Commons mile course (see METs and Me on the website). Do not use an indoor treadmill-- the speed isn't accurate. My mile walk time is ____min____sec

For the following areas, if you have filled out a history with us before, ask for a copy. We don't want you to waste time looking up stuff you've looked up before.

Past Medical History Check the box next to all that you have or have had:

- high cholesterol thyroid disease emphysema hepatitis pancreatitis
- liver disease drug abuse kidney disease diverticulosis neuritis or neuralgia
- tuberculosis jaundice osteoporosis STD (sex transmitted) imprisonment
- asthma diabetes cancer heart trouble gout
- high blood pressure arthritis alcoholism ulcer or acid reflux stroke
- blood clotting disorder glaucoma mental illness genetic disease hyperactivity

Marital Status single divorced married-- name of spouse _____

Pregnancies Females only. Sorry. Number _____ Deliveries _____ Living children _____ Miscarriages or abortions _____

Major Hospitalizations Do not include normal pregnancies:

Year	Operation or Illness <input type="checkbox"/> None	City and State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History Consider only natural parents, brothers, and sisters. Approximate age, if you know, when condition developed:

	Living?	Age	Hypertension	Diabetes	Cholesterol	Stroke	Heart Attack	Cancer type(s) and age
Natural Father	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> _____
Natural Mother	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> _____
_____	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> _____
_____	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> _____
_____	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> _____
_____	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> age _____	<input type="checkbox"/> _____

Current Medication <input type="checkbox"/> None	Dose	Frequency	Dose	Frequency
1 _____	_____	_____	5 _____	_____
2 _____	_____	_____	6 _____	_____
3 _____	_____	_____	7 _____	_____
4 _____	_____	_____	8 _____	_____

Medication Allergies <input type="checkbox"/> None	Reaction	Reaction
1 _____	_____	3 _____
2 _____	_____	4 _____

Immunizations and Tests Enter approximate year done, if you remember. Ignore this section if you have done this DBPE before.

- Colonoscopy _____ EGD/esophagoscopy _____ Mammogram _____ Pap smear _____ Treadmill _____
- Tetanus _____ Herpes zoster (shingles) _____ Hepatitis B _____ Pneumonia _____ Influenza _____

Richard Douglas Iliff, MD
Database Review of Systems

If any of these items are not a problem for you, feel free to answer No. This isn't a lie-detector test!

- Social** Yes No Are you currently smoking? If so, how many cigarettes per day? _____
 Yes No Do you use alcohol? If so, how many drinks do you have in a typical week? _____
 No Yes Do you always wear seatbelts when driving, no matter how far?
 No Yes Do you get physical activity of moderate intensity at least 3 times a week?
 Yes No Do you take marijuana or other illegal drugs?
- Constitutional** Yes No Have you gained or lost more than 10 pounds in the last 6 months?
 Yes No Are you experiencing unusual loss of energy, fatigue, or sleep problems?
 Yes No Do you have difficulty either falling asleep or staying asleep?
 Yes No Are you more hungry or thirsty than usual?
- Eyes** Yes No Is your vision getting worse?
 Yes No Do your eyes hurt or itch frequently?
 Yes No Do you ever have double vision, or see colored halos around lights?
- ENT** Yes No Do you have difficulty hearing?
 Yes No Do you experience dizziness often?
 Yes No Do you have constant ringing, buzzing, or noise in your ears?
 Yes No Do you have pain or bleeding in from your teeth, gums, or throat?
- Cardiovascular** Yes No Do you ever get pains or tightness in your chest?
 Yes No Does every little effort leave you short of breath?
 Yes No When you walk, do you get cramps in your legs which go away when you rest?
 Yes No Have you ever been told you have a heart murmur?
 Yes No Do you get short of breath when you lie flat?
 Yes No Have your ankles been swelling?
 Yes No Does your heart race or do "flip-flops" in your chest?
- Respiratory** Yes No Do you have to wheeze or gasp to breathe, or cough up blood?
 Yes No Do your frequently cough up phlegm (thick mucus)?
 Yes No Do you cough a lot?
 Yes No Do you wake up at night short of breath?
- Gastrointestinal** Yes No Are you troubled by heartburn?
 Yes No Is it difficult or painful for you to swallow?
 Yes No Do you often experience pain in your belly or bleeding from your rectum?
 Yes No Do you experience constipation or black stools?
- Genitourinary** Yes No Do you feel like you have to urinate more often than usual?
 Yes No Are you homosexual or bisexual?
 Yes No Do you wet your pants or wet your bed?
 Yes No Do you frequently get up at night to urinate? If so, how often? _____
 Yes No Are you having any sexual difficulties?
- Women** Yes No Have you had any unusual vaginal bleeding, itching, pain, or discharge?
 Yes No Have you had lumps or pain in your breasts or nipples?
 Yes No Are you having menstrual periods? If so, what was the month and year of the last? ____/____
- Men** Yes No Is your urine stream weak, slow, or hard to start or stop?
 Yes No Do you have lumps or pain in your testicles?
- Musculoskeletal** Yes No Are you troubled by stiff, painful, or swollen joints?
 Yes No Do your feet hurt?
 Yes No Are you bothered by frequent back pain?
- Skin** Yes No Have you experienced changes in a wart or mole, or any other skin problems?
- Neurological** Yes No Are you having a problem with balance, numbness, weakness, or fainting?
 Yes No Do you get headaches frequently?
- Psychiatric** Yes No Have you felt lonely or depressed, or considered suicide?
 Yes No Do you lose your temper often?
 Yes No Do you have panic attacks or anxiety spells?
 Yes No Do you have memory problems, or difficulty concentrating?
- Endocrine** Yes No Are you often too hot or too cold, or experience unusual dryness of your hair or skin?
- Lymphatic** Yes No Have you noticed persistent swellings in your armpits, groin, or neck?
- Allergic** Yes No Has there been any change in your seasonal allergies, or reaction to insect bites or stings?