

GENERAL HEALTH CHECKLIST

Name _____ Age _____ Date _____

Read the following list carefully and make a check (✓) next to each item that applies to you.

_____ recent change in health
_____ always feel sick
_____ trouble sleeping
_____ trouble falling asleep
_____ feeling weak all over
_____ loss of strength
_____ get tired easily
_____ get sick often

_____ loss of appetite
_____ weight has changed
_____ often have fever or chills
_____ loss of hearing
_____ ringing in ears
_____ strange sounds in ears
_____ sinus problems

_____ pain in chest
_____ pain when taking a breath
_____ difficulty in breathing
_____ difficulty in taking a full breath
_____ frequent cough
_____ coughing spells

_____ difficulty breathing during work or exercise
_____ breathing problems when lying down
_____ frequent colds
_____ frequently aware of heartbeat
_____ heartbeat seems irregular
_____ high blood pressure

_____ frequent nausea or upset stomach
_____ heartburn
_____ frequent vomiting
_____ stomach pain
_____ frequent stomach cramps

_____ frequent use of laxatives
_____ often use medicine to settle stomach
_____ increased appetite
_____ often thirsty

_____ muscle weakness
_____ tics or twitching muscles
_____ muscle spasms/pain
_____ trouble walking
_____ balance problems
_____ tremors or shakiness
_____ problems with dropping things
_____ trouble walking up stairs
_____ numbness in arms or legs
_____ tingling or burning skin
_____ loss of feeling on skin
_____ loss of sense of touch
_____ blackouts or fainting spells

_____ seizures or fits
_____ headaches
_____ having trouble keeping track of time
_____ forgetting things
_____ having memory problems
_____ getting lost while driving
_____ hearing unusual sounds or voices
_____ seeing unusual things
_____ having strange feelings
_____ getting confused
_____ having trouble concentrating
_____ having trouble reading or writing
_____ having problems following a conversation

_____ menstrual periods have stopped
_____ painful menstrual periods
_____ change in menstrual flow
_____ irregular menstrual periods

_____ pain during sexual intercourse
_____ change in sexual performance
_____ change of life
_____ hot flashes

Continued

- rarely exercise
- have a regular exercise plan
- exercise on weekends
- eat a balanced diet
- have a poor diet
- eat three meals a day

- often use medicine like aspirin or laxatives
- do not drink alcohol
- have alcoholic drink a few times a week
- have alcoholic drink every day
- have several alcoholic drinks every day
- have a problem with alcohol

- eat at irregular times
- take vitamins
- always see doctor for yearly checkup
- have had checkup in last year
- have not seen a doctor for many years

- have had a problem with alcohol in the past
- do not smoke cigarettes
- smoke less a than pack of cigarettes daily
- smoke a pack of cigarettes daily
- have smoked for less than five years

- am currently being treated by a physician
- always have regular dental checkups
- have not seen dentist in last year
- am taking medication prescribed by doctor

- have smoked for longer than five years
- work with chemicals or solvents
- work with fertilizers or weedkillers
- work with paint or glue

- history of head injury
- history of heart attack
- history of stroke
- history of hypertension

- history of diabetes
- history of seizure disorder or epilepsy
- history of cancer
- hospitalization in last year

List any other health problem you might have:

List all medications that you are now taking:

List the names of the doctors treating you and the illnesses you are being treated for:
