

PATIENT'S PERSONAL HISTORY FORM

Please fill out and bring with you on the day of your appointment. **DO NOT MAIL IN.** Please do not use any body oil or cream the day of your appointment as we may be doing an EKG and the patches we use will not stick.

NAME _____ Age _____ Date _____

Occupation _____ Birth Place _____ Birth Date _____

SOC. SEC. NO. _____/_____/_____

Dr. _____ Date of last Physical Examination _____

List all States and Countries _____

in which you have lived _____

Chief Complaints: (Please list all symptoms.)

1. _____ 3. _____

2. _____ 4. _____

Please answer each of the following questions by placing an (✓) in the "yes" box if your answer to the question is yes, or by placing an (✓) in the "no" box if your answer to the question is no. Fill in "who" and "when" information when necessary.

FAMILY HISTORY

Has Any Blood Relative Ever Had:

- Cancer, Including Leukemia NO YES WHO _____
- Tuberculosis NO YES WHO _____
- Diabetes NO YES WHO _____
- Heart Trouble NO YES WHO _____
- Heart Attack NO YES WHO _____
- High Blood Pressure NO YES WHO _____
- Stroke NO YES WHO _____
- Epilepsy NO YES WHO _____
- Bleeding Disorder NO YES WHO _____
- Asthma NO YES WHO _____
- Allergies NO YES WHO _____
- Liver Disease NO YES WHO _____
- Migraine Headaches NO YES WHO _____
- Alcoholism NO YES WHO _____
- Emphysema NO YES WHO _____
- Stomach or Duodenal Ulcer NO YES WHO _____
- Kidney Disease NO YES WHO _____
- Glaucoma NO YES WHO _____
- Sickle Cell Anemia NO YES WHO _____

Family History (continued)

- Other Anemia NO YES WHO _____
- Mental Illness NO YES WHO _____
- Suicide NO YES WHO _____
- Birth Defects NO YES WHO _____
- Other Serious Disease NO YES WHO _____

PERSONAL HISTORY

- Do You Smoke? NO YES
 If Yes, What _____
 How Much _____
- Do You Drink?
 Beer NO YES
 Wine NO YES
 Other Alcoholic Beverages NO YES
 How Much of Each? _____
- Are You on a Special Diet? NO YES
 What Diet? _____

	Living	Dead	Age at Death	Cause of Death
Father				
Mother				
Brother or Sister				
Husband or Wife				
Son or Daughter				

NOTE: This is a confidential record and will be kept to this facility or your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Personal History (continued)

Have You Lost Weight in the Past Year? NO YES
Do You Have Difficulty Sleeping? NO YES
Are You Overweight? NO YES

X-RAYS

Have You Had Any of these X-Rays? If Yes, When?
Chest NO YES WHEN _____
Stomach NO YES WHEN _____
Colon NO YES WHEN _____
Gall Bladder NO YES WHEN _____
Back NO YES WHEN _____
Kidney NO YES WHEN _____
Extremities NO YES WHEN _____
Other NO YES WHEN _____
Have You Ever Had X-Ray Treatments? NO YES WHEN _____

IMMUNIZATIONS

Have You Been Immunized Against:
Small Pox NO YES LAST SHOT _____
Tetanus NO YES LAST SHOT _____
Polio (shots or oral vaccine) NO YES LAST SHOT _____
Measles NO YES LAST SHOT _____
German Measles NO YES LAST SHOT _____
Other _____ NO YES LAST SHOT _____

ALLERGIES

Are You Allergic To Any of the Following:
Penicillin NO YES
Sulfa NO YES
Other Antibiotics NO YES
Any Other Drug or Medicine NO YES
Any Food NO YES
Nail Polish or Cosmetic NO YES
Other _____ NO YES

MEDICINES

Are You Taking Any Medicines Regularly Now? NO YES WHAT _____

Medicines (continued)

Have You Ever Taken:
Insulin NO YES WHEN _____
Cortisone NO YES WHEN _____
Thyroid Medicine NO YES WHEN _____
Male or Female Hormones NO YES WHEN _____
Blood Pressure Medicine NO YES WHEN _____
Tranquilizers or Sedatives NO YES WHEN _____
Birth Control Pills NO YES WHEN _____
Other NO YES WHEN _____

DEVICES

Do You Use:
Eyeglasses NO YES
Contact Lenses NO YES
Hearing Aid NO YES
Dentures NO YES
Neck Brace NO YES
Back Brace NO YES
Other Brace NO YES
Artificial Limb NO YES
Truss NO YES
Pacemaker NO YES
I.U.D. NO YES
Diaphragm NO YES
Other Device NO YES

OPERATIONS

Have You Had Any of these Operated Upon:
Tonsils NO YES WHEN _____
Appendix NO YES WHEN _____
Gall Bladder NO YES WHEN _____
Stomach NO YES WHEN _____
Small Intestine NO YES WHEN _____
Kidney NO YES WHEN _____
Colon NO YES WHEN _____
Thyroid NO YES WHEN _____
Hernia (Rupture) NO YES WHEN _____

Women

Breast NO YES WHEN _____
Uterus NO YES WHEN _____
Ovaries NO YES WHEN _____

Men

Prostate NO YES WHEN _____
Other NO YES WHEN _____

DIAGNOSED DIFFICULTIES

Do You Now, or Have You in the Past, Had Any of the Following:
Migraine Headaches NO YES HAVE NOW YES PAST WHEN _____
Epilepsy or Convulsions NO YES HAVE NOW YES PAST WHEN _____
Stroke NO YES HAVE NOW YES PAST WHEN _____
Glaucoma NO YES HAVE NOW YES PAST WHEN _____
Cataracts NO YES HAVE NOW YES PAST WHEN _____
Blindness Either Eye NO YES HAVE NOW YES PAST WHEN _____
Ear Infections NO YES HAVE NOW YES PAST WHEN _____
Deafness NO YES HAVE NOW YES PAST WHEN _____
Asthma NO YES HAVE NOW YES PAST WHEN _____
Hay Fever NO YES HAVE NOW YES PAST WHEN _____
Chronic Bronchitis NO YES HAVE NOW YES PAST WHEN _____
Emphysema NO YES HAVE NOW YES PAST WHEN _____
Tuberculosis NO YES HAVE NOW YES PAST WHEN _____

DIAGNOSED DIFFICULTIES (continued)

Abnormal Chest X-Ray	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Heart Murmur as an Adult	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Abnormal Electrocardiogram	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Enlarged Heart	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Heart Attack	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Rheumatic Fever	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Angina	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
High Blood Pressure	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Gall Stones	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Hepatitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Cirrhosis of Liver	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Stomach or Duodenal Ulcer	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Abnormal Stomach X-Ray	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Colon or Bowel Trouble	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Rectal Trouble	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Hemorrhoids or Piles	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Dysentery or Serious Diarrhea	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Kidney or Bladder Infection	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Kidney Stones	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Other Kidney Disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
What? _____				
Anemia	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
What Kind? _____				
Poor Blood Clotting	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Diabetes	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
On Insulin	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
How Much? _____				
Gout	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Overactive Thyroid	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Underactive Thyroid	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Goiter	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Broken Bones	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Varicose Veins	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Arthritis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Polio	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Phlebitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Syphilis or V.D.	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Gonorrhea	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Recurrent Boils	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Other Skin Disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
What Kind? _____				
Serious Depression	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Serious Emotional Problem	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Nervous Breakdown	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Women				
Menstrual Difficulties	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Ovarian Cyst	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Other Gyn Problems	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
What Kind? _____				
Age Periods Started _____				
Still Menstruating	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
Age Periods Stopped _____				
Why Periods Stopped _____				
Are Your Periods Regular?	<input type="checkbox"/> NO	<input type="checkbox"/> YES _____		
Cystitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Mastitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Breast Cancer	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Other Breast Disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Number of Times Pregnant _____				
Number of Children _____				
Number of Miscarriages _____				
Men				
Prostate Trouble	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Other Illness	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
What? _____				

SYSTEM REVIEW

Do You Have Any of the Following Complaints:

General

Fever	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Chills	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Aches or Pains	<input type="checkbox"/> NO	<input type="checkbox"/> YES
General Weakness	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Memory Loss	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Swollen Glands	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Easy Bruising	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Head

Blurred Vision Not Corrected by Glasses	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Double Vision	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Light Flashes	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Halos Around Lights	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Pain in Your Eyes	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Ear Pain	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Drainage from Ear	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Hearing Difficulty or Deafness	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Buzzing or Ringing in Ears	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Nosebleeds Not Due to Injuries	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Sinus Trouble	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Difficulty Swallowing	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Mouth, Tooth or Tongue Problem	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Persistent Hoarseness	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Severe Headaches	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Other _____	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Skin

Changing Mole	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Rash	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Yellow Skin	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Other Skin Problem _____	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Neck

Swelling	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Lumps	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Stiffness	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Other _____	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Chest, Heart, Lungs

Shortness of Breath	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Poor Exercise Tolerance	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Fluttering of Heart	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Unusual Heartbeat	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Chest Pain or Pressure Attacks	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Frequent Cough	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Coughing Up Blood	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Wheezing	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Night Sweats	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Swollen Ankles	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Leg Cramps	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Other _____	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Gastrointestinal

Poor Appetite	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Indigestion or Heartburn	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Difficulty Swallowing	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Nausea or Vomiting	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Vomiting Blood	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Abdominal Pain or Cramps	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Abdominal Swelling	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Diarrhea	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Constipation	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Change in Bowel Habits	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Pass Blood from Rectum	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Black, Tar-like Bowel Movements	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Other _____	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Kidney

Blood in Urine	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Pain or Burning While Urinating	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Difficulty Passing Urine	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Difficulty Controlling Urine	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Getting Up at Night to Urinate	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Other _____	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Genitalia

Women

Breast Lump	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Discharge from Nipple	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Other Breast Problem	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Vaginal Discharge	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Vaginal Bleeding or Spotting (not with periods)	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Hot Flashes	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Pain with Intercourse	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Possibly Pregnant	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Change in Periods	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Pain Not Associated with Periods	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Other _____	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Men

Breast Lump	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Discharge from Penis	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Sore on Penis	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Lump in Testicles	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Difficulty Having Erections	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Other _____	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Neuromuscular

Weakness in Arm or Leg	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Difficulty with Balance	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Dizzy Spells	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Fainting Spells	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Speech Difficulty	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Other _____	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Bones - Joints

Painful Joints	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Swollen Joints	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Loss of Muscle Strength	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Lump or Swelling in Muscle	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Lump on Bone	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Back Pain	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Other _____	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Endocrine

Thirsty All the Time	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Cold Most of the Time	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Too Warm Most of the Time	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Unusually Tired or Sluggish	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Unusually Jumpy or Nervous	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Psychologic

Do You Find Your Life:		
General Unsatisfactory	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Too Demanding	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Boring	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Satisfactory	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Do You Worry About:

Money	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Job	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Marriage	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Home Life	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Children	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Do You:

Cry Easily	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Feel Inferior to Others	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Feel Shy	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Feel Things Often Go Wrong	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Often Feel Depressed	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Have Irrational Fears	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Feel Anxious or Upset	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Have You:

Seriously Considered Suicide	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Attempted Suicide	<input type="checkbox"/> NO	<input type="checkbox"/> YES