Name__________________________ *Richard Douglas Iliff, MD* Date ___/___/______

Database History Age_____

Highest education level achieved:___________________ **Present occupation:**________________________

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**

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___________________________ [ ] Number of children ______

Pregnancies *Females only. Sorry.* Number______ Deliveries ______ Living children ______ Miscarriages or abortions ______

Major Hospitalizations *Do not include normal pregnancies:*

Year	Operation or Illness [ ] **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	[ ]Y [ ]N	____	[ ] age____	[ ] age____	[ ] age ____	[ ] age____	[ ] age____	[ ]____________________
Natural Mother	[ ]Y [ ]N	____	[ ] age____	[ ] age____	[ ] age ____	[ ] age____	[ ] age____	[ ]____________________
______________	[ ]Y [ ]N	____	[ ] age____	[ ] age____	[ ] age ____	[ ] age____	[ ] age____	[ ]____________________
______________	[ ]Y [ ]N	____	[ ] age____	[ ] age____	[ ] age ____	[ ] age____	[ ] age____	[ ]____________________
______________	[ ]Y [ ]N	____	[ ] age____	[ ] age____	[ ] age ____	[ ] age____	[ ] age____	[ ]____________________
______________	[ ]Y [ ]N	____	[ ] age____	[ ] age____	[ ] age ____	[ ] age____	[ ] age____	[ ]____________________
______________	[ ]Y [ ]N	____	[ ] age____	[ ] age____	[ ] age ____	[ ] age____	[ ] age____	[ ]____________________

Current Medication **[ ]None**	Dose	Frequency		Dose	Frequency
1____________________________	_____	________	6____________________________	_____	_________
2____________________________	_____	________	7____________________________	_____	_________
3____________________________	_____	________	8____________________________	_____	_________
4____________________________	_____	________	9____________________________	_____	_________
5____________________________	_____	________	10___________________________	_____	_________

Medication Allergies **[ ]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?