





# Douglas Williams

## Executive Health Program

### ② PRESENT ILLNESS

#### PRESENT MEDICAL PROBLEMS

Please list any known medical problems that you have at present.

MEDICAL PROBLEM	DATE OF ONSET	COMMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

#### CURRENT MEDICATIONS

Please list all medications that you are currently taking (including insulin, oral contraceptives, over-the-counter medications, vitamins, diet supplements, herbal preparations, etc.).

MEDICATION	TAKEN FOR	DOSAGE	DOSES PER DAY	DATE STARTED
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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## Executive Health Program

### ③ PAST MEDICAL HISTORY

#### SIGNIFICANT PAST ILLNESS

Please list any other illnesses you have had as a child or adult.

ILLNESS	YEAR(S)	COMMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

#### PAST SURGERY

Please list in chronological order any surgeries (hospital and out-patient) that you have had.

TYPE OF SURGERY	YEAR(S)	COMMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

#### DRUG REACTIONS/ALLERGIES

Please list all known reactions/allergies to any medications.

MEDICATION	TYPE OF REACTION/ALLERGY	YEAR(S)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Douglas Williams**  
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**③ PAST MEDICAL HISTORY (CONT.)**

**IMMUNIZATIONS**

1. When was your last tetanus shot? _____		
2. Do you have an annual flu vaccine?	<input type="radio"/> Yes	<input type="radio"/> No
3. Have you had a pneumococcal vaccine (Pneumovax)?	<input type="radio"/> Yes	<input type="radio"/> No
4. Have you had a tuberculosis skin test (PPD or Tine)?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, was it negative?	<input type="radio"/> Yes	<input type="radio"/> No
Date of test? _____		

**DIAGNOSTIC STUDIES**

Bubble in all of the diagnostic studies you have had performed, and enter a four digit year.

TEST	YEAR	Month	COMMENTS
<input type="radio"/> EKG or ECG (Electrocardiogram)	_____	_____	_____
<input type="radio"/> Treadmill or Exercise Stress Test	_____	_____	_____
<input type="radio"/> Chest X-ray	_____	_____	_____
Please include Year/Month for below:			
<input type="radio"/> Bone Densitometry	_____	_____	_____
<input type="radio"/> Sigmoidoscopy or Colonoscopy	_____	_____	_____
<input type="radio"/> Mammogram	_____	_____	_____
<input type="radio"/> Pelvic Exam/Pap Smear	_____	_____	_____

**④ SOCIAL/LIFESTYLE HISTORY**

**PERSONAL INFORMATION**

Sex: <input type="radio"/> Male	<input type="radio"/> Female	Place of Birth: _____
Race: <input type="radio"/> White	<input type="radio"/> Black	<input type="radio"/> Hispanic
	<input type="radio"/> Asian	<input type="radio"/> Other (Specify): _____
1. Are you currently or have you ever been married? <input type="radio"/> Yes <input type="radio"/> No		
If yes, how many times have you been married? _____		
2. Current marital status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed		
If currently married, how many years? _____		
3. Number of children? _____		





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### ④ SOCIAL/LIFESTYLE HISTORY (CONT.)

#### PHYSICAL EXERCISE

1. How do you rate your current level of physical activity compared to others of your same age and sex?  
(Think about both leisure and work activities.)  
 Extremely Inactive     Inactive     Somewhat Inactive     About Average  
 Extremely Active     Active     Somewhat Active
2. Compared to a year ago, how much regular exercise do you currently get?  
 Much Less     Somewhat Less     About the Same     Somewhat More     Much More
3. Are you currently involved in a regular exercise program?     Yes     No
4. How often do you exercise?  
 Never     Rarely     Once a week     Several times a week     Daily  
 What types of exercises? \_\_\_\_\_  
 \_\_\_\_\_

### ⑤ FAMILY MEDICAL HISTORY

#### PARENTS

1. Are you adopted and/or unaware of your biological parents' medical history?     Yes     No  
 (If yes, please move on to the BROTHERS AND SISTERS section.)

Please complete the following information, if you parents' medical history is known.

	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	MAJOR HEALTH PROBLEMS (Bubble in all that apply.)								
Father	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>					<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>					_____	<input type="radio"/> Cancer <input type="radio"/> Diabetes <input type="radio"/> Stroke <input type="radio"/> Heart Attack/M.I. <input type="radio"/> Hypertension <input type="radio"/> Other (Specify): _____ _____
Mother	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>					<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>					_____	<input type="radio"/> Cancer <input type="radio"/> Diabetes <input type="radio"/> Stroke <input type="radio"/> Heart Attack/M.I. <input type="radio"/> Hypertension <input type="radio"/> Other (Specify): _____ _____

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### 5 FAMILY MEDICAL HISTORY (CONT.)

#### BROTHERS AND SISTERS

1. Are you adopted and/or unaware of your biological siblings' medical history?     Yes     No  
 (If yes, please skip ahead to the CHILDREN section.)

Please complete the following information for each of your siblings, if their medical history is known.

SEX	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	MAJOR HEALTH PROBLEMS (Bubble in all that apply.)
<input type="radio"/> Male <input type="radio"/> Female	<input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/>	_____	<input type="radio"/> Cancer <input type="radio"/> Diabetes <input type="radio"/> Stroke <input type="radio"/> Heart Attack/M.I. <input type="radio"/> Hypertension <input type="radio"/> Other (Specify): _____ _____
<input type="radio"/> Male <input type="radio"/> Female	<input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/>	_____	<input type="radio"/> Cancer <input type="radio"/> Diabetes <input type="radio"/> Stroke <input type="radio"/> Heart Attack/M.I. <input type="radio"/> Hypertension <input type="radio"/> Other (Specify): _____ _____
<input type="radio"/> Male <input type="radio"/> Female	<input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/>	_____	<input type="radio"/> Cancer <input type="radio"/> Diabetes <input type="radio"/> Stroke <input type="radio"/> Heart Attack/M.I. <input type="radio"/> Hypertension <input type="radio"/> Other (Specify): _____ _____
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<input type="radio"/> Male <input type="radio"/> Female	<input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/>	_____	<input type="radio"/> Cancer <input type="radio"/> Diabetes <input type="radio"/> Stroke <input type="radio"/> Heart Attack/M.I. <input type="radio"/> Hypertension <input type="radio"/> Other (Specify): _____ _____
<input type="radio"/> Male <input type="radio"/> Female	<input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black; display: inline-block; vertical-align: middle;" type="text"/>	_____	<input type="radio"/> Cancer <input type="radio"/> Diabetes <input type="radio"/> Stroke <input type="radio"/> Heart Attack/M.I. <input type="radio"/> Hypertension <input type="radio"/> Other (Specify): _____ _____

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## Executive Health Program

### 5 FAMILY MEDICAL HISTORY (CONT.)

#### CHILDREN

1. Do you have any biological children?       Yes       No  
 (If no, please skip ahead to the REVIEW OF SYSTEMS section.)

Please complete the following information for each of your children, if their medical history is known.

SEX	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	MAJOR HEALTH PROBLEMS (Bubble in all that apply.)								
<input type="radio"/> Male <input type="radio"/> Female	<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td></tr> </table>					<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td></tr> </table>					_____	<input type="radio"/> Cancer <input type="radio"/> Diabetes <input type="radio"/> Stroke <input type="radio"/> Heart Attack/M.I. <input type="radio"/> Hypertension <input type="radio"/> Other (Specify): _____ _____
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## Executive Health Program

### ⑥ REVIEW OF SYSTEMS

Please indicate whether you have ever had a significant problem with any of the symptoms or conditions listed below.

GENERAL	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	IS THIS STILL A PROBLEM?	COMMENTS
1. Unexplained weight loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
What was the magnitude of this weight loss?				<input type="radio"/> 0-5 lbs. <input type="radio"/> 5-15 lbs. <input type="radio"/> 15-25 lbs. <input type="radio"/> >25lbs.		
2. Unexplained weight gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
What was the magnitude of this weight gain?				<input type="radio"/> 0-5 lbs. <input type="radio"/> 5-15 lbs. <input type="radio"/> 15-25 lbs. <input type="radio"/> >25lbs.		
3. Chronic fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
4. Change in appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
5. Night Sweats	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
6. Fever or chills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
7. Any type of cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	

#### HEART/VASCULAR

8. Chest pain or pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
9. Chest pain with exertion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
10. Heart Attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
11. Rapid/Irregular heartbeats	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
12. Fainting/Lightheadedness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
13. High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
14. Rheumatic fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
15. Calf pain with exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
16. Varicose veins	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
17. Phlebitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
18. Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
19. High blood cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
20. High blood triglycerides	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	

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## Executive Health Program

### ⑥ REVIEW OF SYSTEMS (CONT.)

EYES	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	IS THIS STILL A PROBLEM?	COMMENTS
21. Decrease in vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
Date of last eye exam?	___/___/___					
22. Double vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
23. Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
24. Color blindness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
25. Cataracts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
26. Serious injury to eye	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	

#### EAR-NOSE-THROAT

27. Hearing loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
28. Prolonged exposure to loud noise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
29. Ringing in ears	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
30. Chronic ear infections	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
31. Ruptured eardrum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
32. Snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
33. Sinus infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
34. Allergy related nasal congestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	

#### BONE AND JOINT

35. Chronic joint and muscle pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
36. Low back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
37. Swollen/stiff joints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
38. Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	
39. Gout	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes No	

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### ⑥ REVIEW OF SYSTEMS (CONT.)

ENDOCRINE	DON'T			IF YES, YEAR OF ONSET?	IS THIS STILL A PROBLEM?		COMMENTS
	YES	NO	KNOW		Yes	No	
40. Thyroid disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
41. High blood sugar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
42. Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	

#### PULMONARY

43. Chronic cough or phlegm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
44. Wheezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
45. Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
46. Tuberculosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
47. Bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
48. Pneumonia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
49. Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
50. Coughed up blood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
51. Shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	

#### GASTROINTESTINAL

52. Fatty food intolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
53. Ulcer disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
54. Frequent heartburn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
55. Vomited blood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
56. Gallbladder trouble	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
57. Abdominal pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
58. Jaundice, hepatitis, or cirrhosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
59. Frequent diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
60. Diarrhea caused by milk / lactose intolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	

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### ⑥ REVIEW OF SYSTEMS (CONT.)

GASTROINTESTINAL (CONT).	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	IS THIS STILL A PROBLEM?		COMMENTS
61. Blood in stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
62. Black stool	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
63. Hemorrhoids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
64. Colon polyps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
65. Chronic constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	

#### NEUROPSYCHIATRY

66. Loss of consciousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
67. Vertigo	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
68. Memory Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
69. Seizures or epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
70. Frequent headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
71. Numbness or tingling of arms, legs, or face	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
72. Difficulty sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
73. Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
74. Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
75. Thoughts of suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
76. Nervous breakdown	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
77. Psychiatric or psycho- Logical counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	

#### HEMATOLOGY

78. Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
79. Bleeding disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
80. Previous blood transfusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
81. Enlarged or swollen lymph nodes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	

# Douglas Williams

## Executive Health Program

### ⑥ REVIEW OF SYSTEMS (CONT.)

DERMATOLOGY	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	IS THIS STILL A PROBLEM?		COMMENTS
82. Skin rash	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
83. Skin cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
84. Shingles/herpes zoster	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
85. Skin sores that won't heal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
86. Unusual moles	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
87. Mouth sores that won't heal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
88. Skin or toenail fungus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
89. Psoriasis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
90. Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	

#### GENITOURINARY

91. Sexually transmitted disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
- syphilis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
- gonorrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
- herpes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
92. HIV positive/AIDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
93. Blood in urine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
94. Burning or pain during urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
95. Kidney/bladder infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
96. Kidney stones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
<b>Questions 97-100: Male-specific</b>							
97. Impotence/Erectile dysfunction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
98. Difficulty urinating (starting or stopping)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
99. Awakening to urinate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	
100. Prostate trouble	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	Yes	No	

