



PATIENT'S PERSONAL HISTORY

Name _____

Birth Date _____

Occupation _____

Education _____

Marital Status _____ Religion _____

Ethnicity _____

Past Medical History:

___ Allergies/Hay fever

___ Diabetes

___ Liver Disease

___ Anemia

___ Eye problems

___ Lung Disease

___ Anxiety Disorder

___ Hearing problems

___ Major injuries/illnesses _____

___ Arthritis/ Joint problems

___ Heart Attack

___ Seizures

___ Back problems

___ Heart burn

___ Stroke

___ Bleeding problems

___ Heart murmur

___ Thyroid Disease

___ Blood transfusions

___ Heart problems

___ Ulcers

___ Childhood Diseases

___ High blood pressure

___ Cancer Type: _____

___ Clotting problems

___ Headaches (Severe)

___ Depression

___ Kidney Disease

___ Other: _____

Current Medications: including Vitamins and Herbals:

1. _____

6. _____

2. _____

7. _____

3. _____

8. _____

4. _____

9. _____

5. _____

10. _____

Allergies: (Are you allergic to...?):

Tetanus antitoxin ___ yes ___ no

Penicillin ___ yes ___ no

Sulfa ___ yes ___ no

Other Drugs ___ yes ___ no

PLEASE LIST _____

Foods ___ yes ___ no

Eggs ___ yes ___ no

Cosmetics ___ yes ___ no

Other ___ yes ___ no

PLEASE LIST _____

Past Surgeries:

___ Heart

___ Prostate

___ Skin

___ Back

___ Thyroid

___ Hemorrhoids

___ Head

___ Any Biopsies

___ Breast

___ Appendix

___ Abdomen

___ Other _____

___ Uterus/ Ovary

___ Gallbladder

___ Cesarean

___ Hernia

___ Tonsils

___ Eyes

Family History:	If Living		If Deceased	
	Age	Health	Age At Death	Cause
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers/Sisters				
_____	M F	_____	_____	_____
_____	M F	_____	_____	_____
_____	M F	_____	_____	_____
_____	M F	_____	_____	_____
_____	M F	_____	_____	_____
Husband/Wife		_____	_____	_____
Sons/Daughters	M F	_____	_____	_____
(Circle sex)	M F	_____	_____	_____
	M F	_____	_____	_____
	M F	_____	_____	_____
	M F	_____	_____	_____

Do you know of any blood relative who has had: (check and give relationship)

Stroke_____	Epilepsy_____	Elevated Cholesterol_____
Heart Attack_____	Diabetes_____	Anemia_____
Arthritis_____	Colitis_____	Migraines_____
Hypertension_____	Stomach ulcers_____	Kidney disease_____
Suicide_____	Asthma_____	Thyroid disease_____

Lifestyle/ Social Issues:

- Yes No Do you regularly smoke? Check: ___Cigarettes ___Pipe ___Cigar
For how many years?_____
- Yes No Do you usually drink over 4 cups of coffee per day?
- Yes No Have you ever been concerned about your alcohol use?
- Yes No Has a friend, relative, or co-worker ever expressed concern regarding your use of alcohol or other chemicals?
- Yes No Have you ever tried to restrict your use of alcohol or other chemicals?
- Yes No Have you ever used more alcohol than you planned to use?
- Yes No Do you have difficulty falling asleep?
- Yes No Do you awaken early in the morning without apparent cause?
- Yes No Does your home have a smoke detector?
- Yes No Do you frequently eat fried or fatty foods?
- Yes No Do you drive without a seatbelt?
- Yes No Do you engage in sex/intercourse without contraception?

Immunization/Vaccines:

Last Tetanus?_____ 2nd Measles shot?_____

Last TB shot test and result?_____ Hepatitis B –series of 3 shots?_____

Last Flu shot?_____ Had Chickenpox or its vaccine?_____

Screening Tests:

(Please indicate if you've had any of the following and the results and date of test done, if known):

EKG _____
Sigmoid/ Colonoscopy _____
Cholesterol _____
PSA (Prostate Specific Antigen) _____

General:

Please put an X if you frequently have this problem:

<input type="checkbox"/> Recent weight loss/gain. How much over what period of time? _____	<input type="checkbox"/> Loss of interest in things you normally enjoy
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Excessive anxiety/ worry
<input type="checkbox"/> Weakness	<input type="checkbox"/> Falls
<input type="checkbox"/> Fever	<input type="checkbox"/> Depressed/ Sad
<input type="checkbox"/> Chills/ Night sweats	<input type="checkbox"/> Phobias
<input type="checkbox"/> Insomnia- difficulty falling/staying asleep	<input type="checkbox"/> Memory loss

Head/ Eyes/ Ears/ Nose/ Throat:

<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Ringing/Buzzing ears	<input type="checkbox"/> Dry mouth
<input type="checkbox"/> Dizzy	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Fainting/Blackout	<input type="checkbox"/> Allergies/ Hay fever	<input type="checkbox"/> Sore throats
<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Mouth sores	<input type="checkbox"/> Swallowing difficulty
<input type="checkbox"/> Eye/ Vision problems	<input type="checkbox"/> Sore tongue	<input type="checkbox"/> Thirst
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Frequent sinus infections

Heart / Lungs:

<input type="checkbox"/> Chest pain. Tightness	<input type="checkbox"/> Cough	<input type="checkbox"/> Chills/ Night sweats
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Wheeze	<input type="checkbox"/> Shortness of breath with normal activities
<input type="checkbox"/> Sleep on more than one pillow	<input type="checkbox"/> Swollen legs/ feet	<input type="checkbox"/> Have coughed up blood

Gastrointestinal:

<input type="checkbox"/> Nausea	<input type="checkbox"/> Bloody/ Black stools	<input type="checkbox"/> Appetite change
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Loss of eating control
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Heartburn	
<input type="checkbox"/> Constipation	<input type="checkbox"/> Yellow skin/ jaundiced	

Urinary:

<input type="checkbox"/> Painful urination	<input type="checkbox"/> Difficulty starting urination
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Bloody/ Cloudy urine
<input type="checkbox"/> Trouble holding urine	<input type="checkbox"/> Waking up at night to urinate

Skin:

<input type="checkbox"/> Rash	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Hair loss
<input type="checkbox"/> Hives	<input type="checkbox"/> Easy sun burning	<input type="checkbox"/> Change skin texture - dry or moist
<input type="checkbox"/> Itching	<input type="checkbox"/> New/ Changing mole	

Musculoskeletal/ Neurologic/ Vascular:

- | | |
|--|----------------------------|
| ___ Joint pain | ___ Muscle/ Leg cramps |
| ___ Joint swelling/ redness | ___ Weakness of arm or leg |
| ___ Morning stiffness longer than 1 hour | ___ Tremor |
| ___ Muscle pain | ___ Varicose veins |

For All Men:

- What form of contraception are you/ your partner using? _____
- Lumps or swelling of testicles? _____
- Problems with impotence? _____
- Discharge from the penis? _____
- For men over 40, date of your last rectal exam? _____

For All Women:

- Number of times pregnant? _____
- Total term births? _____
- Total preterm births? _____
- Total miscarriages? _____
- Total therapeutic abortions? _____
- Complications of pregnancy? _____
- Vaginal discharge or irritation? _____ Pelvic pain? _____
- Discomfort with intercourse? _____
- Breast discomfort, lumps, or discharge? _____
- Have you ever had an abnormal Pap smear or been treated with colposcopy? _____
- When was your last pap smear? _____
- Do you do regular self breast exams? _____
- Do you take a calcium supplement? _____ If so, how much? _____

For Menstruating Women:

- Your menstrual periods come every _____ days and last _____ days.
- Date of last menstrual period _____ Was it normal? _____
- Are your periods regular? _____ Do you have bleeding between periods? _____
- Any recent change in your menstrual cycle? _____
- How heavy are your menses? _____
- What method of contraception are you using? _____
- What methods of contraception have you used before? _____

For Menopausal Women:

- How long ago was your last period? _____
- Any vaginal bleeding since menopause? _____
- Date of last mammogram? _____