Patient's Personal History

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Patient No. ______________

Date ______________

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name	First	Middle	Birth Date		Birth Place
Address **City**	**State**	**Zip**	**Home Phone**		**Business Phone**
Occupation	**Medicare No.**	**Medicaid No.**			
Insurance Company	**Insurance No.**		Sex	Marital Status	Religion (optional)
			M F		

Person to Notify ______________ Relationship ______________

Address ______________ Phone Number ______________

Date of Last Physical Examination ______________ Doctor ______________

Family or Referring Physician ______________ Address ______________

FAMILY HISTORY			If Living		If Deceased	
	Sex		Age	Health	Age at Death	Cause
Father						
Mother						
Brothers/Sisters* *(Circle Sex)*						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
Husband/Wife						
Sons/Daughters* *(Circle Sex)*						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				

**Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter.*

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

Stroke ______ Epilepsy ______ Heart attack ______ Rheumatic heart ______

Cancer ______ Suicide ______ Colitis ______ Congenital heart ______

Leukemia______ Migraine ______ Kidney disease ______ Insanity ______

Tuberculosis ______ Asthma ______ Goiter ______ Colon cancer ______

Diabetes ______ Hay fever ______ Arthritis ______ Nervous breakdown______

High blood pressure ______ Bleeding tendency______ Stomach ulcers ______ ______

PERSONAL HABITS: (Circle)

Yes No Did you ever smoke? Cigarettes__ Pipe__ Cigars__# years?__ How many daily?___ Date stopped?________

Yes No **Do you usually drink over 6 cups of coffee per day?**

Yes No **Do you regularly drink alcohol? 1 oz. per day ☐ 2 oz. per day ☐ 4 oz. per day ☐ over 6 oz. ☐**
BEER: 1 bottle per day ☐ 2 bottles per day ☐ over 4 bottles per day ☐.

Yes No **Do you have difficulty in falling asleep?**

Yes No **Do you awaken early in the morning without apparent cause?**

MEDICATIONS:

Are you presently taking any of the following medications? (Circle)

Yes	No	Aspirin, bufferin, anacin	Yes	No	Tranquilizers
Yes	No	Blood pressure pills	Yes	No	Weight reducing pills
Yes	No	Cortisone	Yes	No	Blood thinning pills
Yes	No	Cough medicine	Yes	No	Dilantin
Yes	No	Digitalis	Yes	No	Shots
Yes	No	Hormones	Yes	No	Water pills
Yes	No	Insulin or diabetic pills	Yes	No	Antibiotics
Yes	No	Iron or poor blood medications	Yes	No	Barbiturates
Yes	No	Laxatives	Yes	No	Birth control pills
Yes	No	Sleeping pills	Yes	No	Phenobarbital
Yes	No	Thyroid medicine	Yes	No	Other drugs not listed

List medication taken and dosage:

Medication	No. of times per day	Dosage
________________	___	________________
________________	___	________________
________________	___	________________
________________	___	________________

List medication taken and dosage:

Medication	No. of times per day	Dosage
________________	___	________________
________________	___	________________
________________	___	________________
________________	___	________________

Check immunizations and date:

___Tuberculin____________________ ___Polio (oral)__________________ ___Varivax (Chicken Pox)________

___Pneumococcal (vaccine)_________ ___Polio (injection)______________ ___MMR____________________
(Measles, Mumps and Rubella)

___Hepatitis A___________________ ___Tetanus and Diphtheria_________

___Hepatitis B___________________ ___Other____

Write in names and year of any operations that you have had:

____

____

Name any drugs to which you are allergic:

____

Write in the names of any diseases that you have had which required hospitalization:

____

____

Serious illnesses that you have had: (not requiring hospitalization)

____

____

Serious injuries or accidents:

____

____

____

To be answered by WOMEN only: (Circle)

Yes No Are you still having regular monthly menstrual periods?
Yes No Have you ever had bleeding between your periods? When? ______
Yes No Do you have very heavy bleeding with your periods? When? ______
Yes No Do you feel bloated and irritable before your period?
Yes No Are you now on or have you ever taken the birth control pill? When? ______
Yes No Have you ever had a miscarriage? When? ______
Yes No Have you ever had a discharge from the nipple of your breast? When? ______
Yes No Do you regularly have the cancer test of the cervix? Date of last test ______

How many children born alive ______
How many stillbirths ______
How many premature births ______
Date of last menstrual period ______
How many miscarriages ______
How many cesarean operations ______
Any complication of pregnancy ______

To be answered by men and women: (Circle)

Yes No Do you frequently have severe headaches? (If yes, answer the following):
Yes No Do they cause visual trouble?
Yes No Do they occur on one side of the head?
Yes No Do they awaken you at night from sleep?
Yes No Do they feel like a tight hat band?
Yes No Do they hurt most in the back of the head and neck?
Yes No Does aspirin relieve them?

Yes No Have you ever fainted?
Yes No Spells of dizziness?
Yes No Spells of weakness of an arm or leg?
Yes No Ringing in ears?
Yes No Have you ever had a convulsion?
Yes No Double vision?
Yes No Pains in ear?
Yes No Nosebleeds?

Yes No Do you frequently have bleeding gums?
Yes No Do you frequently have trouble swallowing?
Yes No Do you frequently have hoarseness?
Yes No Do you frequently have a sore tongue?
Yes No Do you frequently have nausea and vomiting?

Have you ever had shortness of breath?: (Circle)

Yes No Doing your usual work?
Yes No Climbing a flight of stairs?
Yes No Which awakens you at night?
Yes No Do you have a chronic cough?
Yes No Which causes you to cough?
Yes No Accompanied by wheezing?
Yes No Have you ever coughed blood?
Yes No Do you cough up much sputum?

Have you ever had chest pain or tightness in the chest which begins when: (Circle)

Yes No When exerting yourself?
Yes No When walking against a wind?
Yes No When walking up a hill?
Yes No After a heavy meal?
Yes No When upset or excited?
Yes No Palpitations
Yes No Do you sleep on more than one pillow?
Yes No Radiates down the arm?
Yes No Disappears if you rest?
Yes No Occurs only at rest?
Yes No When walking fast?
Yes No When walking in cold weather?

If you have chest pain or tightness please explain ______

Have you recently had pain in the stomach which: (Circle)

Yes No Occurs 1 – 2 hours after a meal?
Yes No Is brought on by eating fried foods, gassy foods?
Yes No Awakens you at night?
Yes No Is relieved by antacid medications?
Yes No Is relieved with milk or eating?
Yes No Occurs while eating or immediately after?
Yes No Is relieved by a bowel movement?
Yes No Loss of appetite?

If you have had a change in bowel habit recently answer the following: (Circle)			When or since when?
Yes	No	Crampy pain in the abdomen?	___
Yes	No	Alternating diarrhea and constipation?	___
Yes	No	Pain during or after bowel movement?	___
Yes	No	Mucous in the stool?	___
Yes	No	Blood in the stool?	___
Yes	No	Ribbon-like stools?	___
Yes	No	Black stools?	___
Yes	No	Require use of strong laxatives or enemas?	___

Have you had: (Circle)			
Yes	No	Burning when urinating?	___
Yes	No	Loss of control of bladder?	___
Yes	No	Blood in the urine?	___
Yes	No	Dark colored urine?	___
Yes	No	Trouble starting to urinate?	___
Yes	No	Trouble holding the urine?	___
Yes	No	Getting up frequently at night?	___
Yes	No	Passed a kidney stone?	___

Have you recently had: (Circle)			
Yes	No	Pains in calves of legs when walking?	___
Yes	No	Cramps in legs at night?	___
Yes	No	Pain in the big toe?	___
Yes	No	Varicose veins?	___
Yes	No	Phlebitis or inflamed leg veins?	___
Yes	No	Swelling in the ankles?	___

To be answered by MEN only: Have you ever had: (Circle)

Yes No Loss of sexual activity? For how long? ___

Yes No Treatment for genitals (private parts)?

Yes No Discharge from penis?

Yes No Hernia (rupture)?

Yes No Prostate trouble?

Describe briefly your present medical symptoms:

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