PATIENT PERSONAL HISTORY FORM

Please take time to complete the following information for our files. This information is treated with strict confidentiality and will help us to plan for your health care needs.

NAME_____DATE COMPLETED_____DOB_____

PRIMARY CARE PHYSICIAN/ OTHER PHYSCIANS_____

Reason for Today's Visit (Please describe symptoms):_____
What work-up has been done so far and where: (CAT scan, PET scan, Biopsy, etc) _____

PAST MEDICAL HISTORY

Hospitalizations/surgeries/accidents/injuries

Reason/diagnosis/procedure	Date	Reason/diagnosis/procedure	Date

MEDICAL ILLNESSES OR CONDITIONS: (Conditions you now have or have had in the past)

Please check all that apply

Alcoholism		Cancer; Type		High Blood Pressure	
Anemia		Depression		Osteoporosis	
Arthritis		Diabetes		Prostate problems	
Asthma		Epilepsy (seizure disorder)		Stroke	
Autoimmune disorder		High cholesterol		Thyroid disorders	
Bleeding problem		Heart Attack		Substance Abuse	
Other:					

PLEASE LIST ALL ALLERGIES AND THE REACTION:

_____

CURRENT MEDICATIONS: (Non-prescription medicines, vitamins, laxatives, and herbal remedies)

Drug name and Dose	Frequency per day	Drug name and Dose	Frequency per day

PLEASE USE SEPARATE PAGE IF MORE SPACE NEEDED

IMMUNIZATIONS AND PREVENTATIVE SERVICES: Please check and date all that apply

Pneumonia vaccine		Eye exam		Dental exam cleaning	
Flu vaccine		Colonoscopy		Mammogram	
PAP smear		Bone density			

FAMILY MEDICAL HISTORY:

Relation	Age	Disease	

SOCIAL/PERSONAL HISTORY: (Please check all that apply)

Occupation: _____ Retired_____ Full/part time_____ Education completed: _____
Marital Status: _____ Living arrangements: Alone ____ Spouse ____ Family____
Tobacco use/type: Cigarettes ___ Cigars ___ Amount per day _____ Years used _____ Date quit _____
Alcohol use: Type _____ Amount per day _____ Recreational drug use: Type _____ Frequency _____

PATIENT NAME: _____

REVIEW OF SYSTEMS: (Please check any symptoms you have now or have had in last 6 months)

	Yes	No		Yes	No
weight loss	_____	_____	nausea/vomiting	_____	_____
weight gain	_____	_____	breast pain/mass	_____	_____
fatigue	_____	_____	urinary changes	_____	_____
fever/chills	_____	_____	bleeding	_____	_____
night sweats	_____	_____	blood clots	_____	_____
sinus congestion	_____	_____	lymphadenopathy	_____	_____
hearing loss	_____	_____	joint pain	_____	_____
vision changes	_____	_____	back pain	_____	_____
shortness of breath	_____	_____	seizures	_____	_____
swelling/edema	_____	_____	confusion/memory loss	_____	_____
cough	_____	_____	anxiety	_____	_____
chest pain	_____	_____	depression	_____	_____
diarrhea	_____	_____			
constipation	_____	_____			
abdominal pain	_____	_____			
rectal bleeding	_____	_____			

Gynecological history (women):

Number of pregnancies _____ number of deliveries ____ number of miscarriages and abortions ____

age at onset of periods ____ periods occur every ____ days and last ____ day's onset of last period _____

age at menopause___ birth control pills ____ hormone replacement therapy____

Additional Comments: _____

_____

_____

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of patients (or guardian): _____ Date: _____

Doctor's Signature: _____ Date: _____