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 PREVENTITIVE 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	If deceased, Cause and age of death

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 _____
Exposure to: second- hand smoke _____ Solvents/chemicals _____ Asbestos _____
Alcohol use: Type _____ Amount per day _____ Recreational drug use: Type _____ Frequency _____
Are you sexually active _____ Contraception (birth control) used: _____
Religious or cultural needs: _____

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

GENERAL: Weight loss _____ weight gain _____ fatigue or weakness _____ fever, chills, or night sweats_____

EYES: blurred vision_____ double vision ____ spots in eyes ____ eye pain/irritation_____
EARS-NOSE-THROAT: Chronic headaches _____ hearing loss ____ ringing in ears ____ ear pain ____ chronic nasal congestion _____ nose bleeds ____ bleeding gums _____ sore throat ____ dental issues ____ hoarseness/voice changes_____

RESPIRATORY: Shortness of breath at rest _____ or with exercise ____ cough greater than 3 weeks ____ wheezing ____ coughing up blood ____ pneumonia ____ history of TB_____
CARDIOVASCULAR: Chest pain ___ heart fluttering/racing ___ difficulty breathing while lying down ___ leg swelling ___ angina ___
BREAST: Breast lump ___ breast pain ___ nipple discharge ___ practice breast self exam monthly ____ breast biopsy ___

GASTROINTESTINAL: Stomach pains ____ nausea ___ vomiting ___ diarrhea____ constipation ___ frequent heartburn ___ difficulty swallowing ___ bloating ___ blood in stool ___ rectal pain ___ hemorrhoids_____
GENITOURINARY (Men**):** Frequent urination (often at night) ____ urgency/pain with urination ___ bloody urine ___ discharge from penis ___ trouble starting urination ___ loss of bladder control ___ sexually transmitted disease ___ difficulty having erections ___
GENITOURINARY (Women**):** Frequent urination (often at night) ___ urgency/pain with urination ___ bloody urine ___ frequent urinary infections ___ incontinence ___ vaginal bleeding ___
hot flashes ___ mother took DES during pregnancy ___ irregular periods ___ sexually transmitted disease ____
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____

LYMPHATIC/HEMATOLOGIC: Unusual/painful lymph node swelling (in neck, arm pit, or groin) _____
blood clots ___ bruise easily ___ unusual bleeding ___ abnormal blood counts _____
MUSCULOSKELETAL: Limb or joint pains ___ limb or joint swelling/stiffness/redness ___
muscle spasms or twitching ___ recurring back/neck pain ___
NEUROLOGIC: Seizures ___ tremors/shakiness _____ limb weakness ___ numbness/tingling ___
stroke/TIA (mini stroke) ___ history of significant head injury ___ altered consciousness or black –outs ___
PSYCHOLOGIC: Lapses in memory ___ periods of confusion ___ difficulty concentrating ___ depression ___
SKIN: rash ___ skin cancer ___ shingles ___
ENDOCRINE: Unexpected changes in: tolerance to heat ___ tolerance to cold ___ excessive thirst/hunger ___

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: _____