PATIENT'S PERSONAL HISTORY

Patient No:

Date: _____

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

Last Name	First		Middle
Address (Include Apartment, House or Box #)	City	State	Zip Code
Sex (M/F)	Birth Date	Birth Place	Occupation
Home Phone	Business Phone		Marital Status
Person to Notify for Emergency			Relationship
Address			Phone Number
Date of Last Physical Examination			Doctor who did last exam
Primary Care Doctor			Referring Doctor

FAMILY HISTORY – Please complete:

Relative	Age	List Any Diseases	If Deceased, Cause of Death
Father			
Mother			
Father's Parent's (M)			
(F)			
Mother's Parent's (M)			
(F)			
Brother (B) or ( )			
Sister (S) ( )			
( )			
( )			
( )			
Children: Son (S)			
Daughter (D)			
( )			
( )			

Do you know of any blood relative that has or had (Circle and Give Relationship)

Stroke	_____	Epilepsy	_____	Heart Attack	_____	Rheumatic Hearth	_____
Cancer	_____	Suicide	_____	Stomach Ulcers	_____	Insanity	_____
High Blood Pressure	_____	Migraine	_____	Kidney Disease	_____	Congenital Heart Defect	_____
Tuberculosis	_____	Asthma	_____	Arthritis	_____	Other Glandular or Endo Problems	_____
Diabetes	_____	Hay Fever	_____	Colitis	_____	Goiter	_____
Leukemia	_____	Bleeding Tendency	_____	Nervous Breakdown	_____	Hyper or Hypo Thyroid	_____

PERSONAL HABITS: (Circle and Check Where Applicable)

Yes No Do you regularly smoke? Cigarettes ☐ Pipe ☐ Cigar ☐ Former smoker ☐
Counseled to quit? ☐ Passive smoke exposure ☐

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

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

Yes No Regular exercise?

Yes No Drug Use?

Yes No HIV/High Risk?

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

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

_____

_____

Name any drugs to which you are allergic:

_____

_____

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

_____

_____

_____

_____

Serious Illnesses which you have had: (not requiring hospitalization)

_____

_____

_____

_____

Serious injuries or accidents:

_____

_____

_____

Describe briefly your medical symptoms:

_____

_____

_____

If diabetic, when and how was the diagnosis made?

What medicines have you been on and what are you now taking?

Current dietary regimen:

Current home monitoring regimen:

Do you know your last Glycohemoglobin (A1C) result?:

Any complications:

HAVE YOU HAD ANY OF THE FOLLOWING DURING THE PAST ONE-YEAR?

- PLEASE ANSWER ALL QUESTIONS AND CIRCLE NO OR YES -

CONSTITUTIONAL		
Recent weight change	No	Yes
Fever	No	Yes
Night sweats or chills	No	Yes
Fatigue	No	Yes
Daytime drowsiness	No	Yes
Changes in sleep	No	Yes

EYES		
Eye disease	No	Yes
Glaucoma	No	Yes
Pain	No	Yes
Bulging	No	Yes
Double Vision	No	Yes

ENT

Sinus problems	No	Yes
Persistent hoarseness	No	Yes
Post-nasal drip	No	Yes
Runny nose	No	Yes
Seasonal allergies	No	Yes
Broken nose	No	Yes

CARDIOVASCULAR

Heart problems	No	Yes
Chest pain	No	Yes
Fast Heart beat	No	Yes
Heart murmur	No	Yes
Swelling feet or ankles	No	Yes
Blood clots	No	Yes
Rheumatic fever	No	Yes

RESPIRATORY

Frequent cough	No	Yes
Sputum production	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
History of tuberculosis	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Stomach ulcers	No	Yes
Gastric reflux / heartburn	No	Yes
Liver problems / hepatitis	No	Yes
Diarrhea	No	Yes
Constipation	No	Yes

GENITOURINARY

Burning or painful urination	No	Yes
Kidney problems	No	Yes
Blood in urine	No	Yes
Frequent urinary infections	No	Yes
Frequent or night urination	No	Yes

To be answered by MEN only: Have you had? (circle)

Loss of sexual activity	No	Yes
Hernia (rupture)	No	Yes
Treatment for genitals	No	Yes
Discharge from penis	No	Yes

To be answered by WOMEN only: Have you had? (circle)

Are you still having monthly menstrual periods?	No	Yes
Have you ever had bleeding between your periods?	No	Yes
Do you have very heavy bleeding with your periods?	No	Yes
Are you now or have you ever taken birth control pills?	No	Yes
Have you ever had a discharge from the nipple of your breast?	No	Yes
Do you regularly have the cancer test of the cervix?	No	Yes
How many children born live?	_____	
How many miscarriages?	_____	
How many cesarean operations?	_____	
Date of last menstrual period?	_____	
Age of first period?	_____	

MUSCULOSKELETAL

Joint stiffness or swelling	No	Yes
Weakness of muscles	No	Yes
Difficulty walking	No	Yes
Pain in calves of legs when walking	No	Yes
Cramps in legs at night?	No	Yes
Pain in the big toe?	No	Yes
Varicose veins?	No	Yes
Phlebitis of inflamed leg veins?	No	Yes
Swelling in the ankles?	No	Yes
Numbness or tingling in toes/fingers	No	Yes

Pain you are unable to manage? Location _____ What are you doing for it?_____

SKIN

Rash	No	Yes
Persistent itching	No	Yes

NEUROLOGICAL

Frequent headaches	No	Yes
Convulsions or seizures	No	Yes
Tremors	No	Yes
Stroke	No	Yes

PSYCHIATRIC

Memory loss or confusion	No	Yes
Depression	No	Yes
Anxiety	No	Yes

ENDOCRINE

Thyroid disease	No	Yes
Sweating	No	Yes
Thyroid Enlargement or Lumps	No	Yes
Diabetes	No	Yes

HEMATOLOIGIC/LYMPHATIC

Easily bruising or bleeding	No	Yes
Anemia	No	Yes

ALLERGIC/IMMUNOLOGIC

Medication allergies	No	Yes
Food allergies	No	Yes