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PATIENT'S PERSONAL HISTORY

Confidential Record: Information contained herein will not be released without your authorization

Last Name	*First Name*	*Middle Initial*	*Age*	*Today's Date*

Country of Birth	*Religion*	*Occupation*	*Date of Last Physical Exam*

Reasons for Physical Examination or Problems you wish to discuss:

1. ______________________ *4.* ______________________

2. ______________________ *5.* ______________________

3. ______________________ *6.* ______________________

FAMILY HISTORY	If Living		If Deceased	
	Age	**Health**	**Age at Death**	**Cause**
Father's Name				
Mother's Name				
Brothers/Sisters' Names (Circle Sex) M F				
M F				
M F				
M F				
M F				
Husband/Wife's Name				
Children's Name(s) (Circle Sex) M F				
M F				
M F				
M F				
M F				

FAMILY HISTORY

Check if any *blood relative* has or has had any of the following and enter relationship.

	Yes	No	Relationship
Hypertension	☐	☐	______
High Cholesterol	☐	☐	______
Heart Attacks	☐	☐	______
Heart Murmur	☐	☐	______
Stroke	☐	☐	______
Bleeding or Blood Clots	☐	☐	______
Diabetes	☐	☐	______
Thyroid Disease or Nodules	☐	☐	______

	Yes	No	Relationship
Dementia	☐	☐	______
Asthma	☐	☐	______
Emphysema	☐	☐	______
Tuberculosis	☐	☐	______
Pneumonia	☐	☐	______
Sleep Apnea	☐	☐	______
Stomach Ulcers	☐	☐	______
Colitis	☐	☐	______
Arthritis	☐	☐	______
Immune Deficiency	☐	☐	______

	Yes	No	Relationship
Gout	☐	☐	______
Kidney Failure	☐	☐	______
Kidney Stones	☐	☐	______
Cancer	☐	☐	______
Leukemia	☐	☐	______
Seizures	☐	☐	______
Depression	☐	☐	______
Schizophrenia	☐	☐	______
Psychiatric Hospitalization	☐	☐	______

PAST HISTORY (Personal)

Have you had any of the following illnesses?

	Yes	No
Rheumatic Fever	☐	☐
Angina Pectoris	☐	☐
Heart Attack	☐	☐
Other Heart Disease	☐	☐
Hypertension	☐	☐
Elevated Cholesterol	☐	☐
Anemia	☐	☐
Bleeding or Excess Clots	☐	☐
Gout	☐	☐
Seasonal Allergies	☐	☐
Asthma	☐	☐
Frequent Lung Infections	☐	☐
Tuberculosis	☐	☐
Emphysema	☐	☐
Sleep Apnea	☐	☐
Thyroid Disease or Nodules	☐	☐

	Yes	No
Diabetes	☐	☐
Cancer	☐	☐
Kidney Disease	☐	☐
Frequent Kidney or Bladder Infections	☐	☐
Stomach Ulcers	☐	☐
Irritable Bowel	☐	☐
Colitis	☐	☐
Gallbladder Disease	☐	☐
Hepatitis	☐	☐
Arthritis	☐	☐
Migraine Headache	☐	☐
Seizures	☐	☐
Others (list)	☐	☐

______

______

Operations: List and indicate approximate year.

______

______

______

______

______

Hospitalizations (other than operations): *List reasons and approximate dates.*

______

______

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Serious Injuries: List and give approximate dates:

______

______

______

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______

Diagnostic X-Rays: List and give approximate dates and results:

______

______

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Immunizations: Please give dates.

Pneumovax 23 ______ Tetanus/Pertussis ______

Prevnar 13 ______ Last TB Test ______

Shingles Vaccine ______

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list medications and the reaction you had to them:

______

______

______

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PERSONAL HABITS

1. ☐ Did you ever smoke cigarettes? Yes ☐ No ☐
   ☐ Did you ever smoke a pipe or cigars? Yes ☐ No ☐
   How long have you been smoking? ____________ Years
   ☐ Cigarettes ☐ Pipe ☐ Cigars
   Number per day? ____________
   ☐ Former smoker: Stopped ____________ years ago
2. Check if you regularly drink:
   ☐ Hard liquor ☐ 1-3 oz. per day ☐ Over 3 oz. per day
   ☐ Beer/Wine Amount ____________
3. Do you drink coffee? Yes ☐ No ☐ 3 or more cups ☐
4. Do you have difficulty sleeping? Never ☐ Often ☐ Sometimes ☐
5. Have you used recreational drugs? Never ☐ Often ☐ Sometimes ☐

OCCUPATIONAL

	Yes	No
Are you presently unemployed?	☐	☐
Are you dissatisfied with your present type of work?	☐	☐
Does your work involve unusual work, exposure to dust, noise, radioactivity, etc.?	☐	☐
Do you have more than one job?	☐	☐
Do you work more than 60 hours a week?	☐	☐
Do you get along poorly with your fellow employees and/or your supervisors?	☐	☐
Are you unable to perform any work because of disability?	☐	☐
Are you retired?	☐	☐
If retired, have you had difficulty adjusting to retirement?	☐	☐

AIDS RISK ASSESSMENT

Did you ever share needles to shoot drugs into your veins or under your skin?	☐	☐
Have you ever had sex with someone who used needles to shoot drugs?	☐	☐
Have you ever had sex with someone who has AIDS or a positive test for antibody to the AIDS virus?	☐	☐
Have you ever had sex with a man who had sex with other men?	☐	☐
Were you born in or have you lived in a country with a high number of AIDS cases?	☐	☐
Are you a hemophiliac? Is your sex partner a hemophiliac?	☐	☐
Have you had sex for money or drugs? Have you had sex with someone who sells sex for money or drugs?	☐	☐
Did you or your sex partner receive blood between 1977 and 1985?	☐	☐
Have you had sex with multiple partners in the last 12 months?	☐	☐

MARITAL/FAMILY

	Yes	No
Has there been a recent change in your marital status?	☐	☐
Do you have any sexual problems?	☐	☐
Do you have any serious problems with your children?	☐	☐
Is your present home life causing unhappiness?	☐	☐
Does anyone in your family have a serious illness or disability?	☐	☐
Does anyone in your family have a drug or alcohol problem?	☐	☐

SOCIAL HISTORY

Have you recently lived or traveled outside of the U.S.?	☐	☐
Did you complete high school?	☐	☐
Did you attend and/or complete college?	☐	☐
Were you rejected from the Military Service?	☐	☐
Have you ever been rejected for life or health insurance or had to pay an extra premium?	☐	☐
Do you eat less than three meals a day?	☐	☐
Do you have special food customs or restrictions?	☐	☐
Have you ever been treated for a drinking problem?	☐	☐
Do you exercise less than three times a week?	☐	☐
Are you active in political, community, or church activities?	☐	☐
Do you have a hobby or hobbies?	☐	☐

Please identify your hobby or hobbies:

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MEDICATIONS

Current Medications. Include drug name, dosage, number of times taken per day. (Include over the counter meds.) Please use other side of this page if necessary.

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Review of Systems:

A. General

	Yes	No
Do you worry a lot about your health?	☐	☐
Do you usually feel tired or worn out?	☐	☐
Do you feel depressed a lot of the time?	☐	☐
Have you recently noticed that heat or warm weather bothers you?	☐	☐
Have you recently been drinking more water or fluids?	☐	☐
Has there been any unusual weight gain or loss recently?	☐	☐

B. Skin

Have you noticed:		
any change in the color of your skin?	☐	☐
any skin rashes or itches?	☐	☐
unusually dry skin?	☐	☐
any growth on your skin that bothers you?	☐	☐
any sores or wounds that do not heal?	☐	☐
any change in the color or size of warts?	☐	☐

C. Eyes

Have you had:		
any pain in your eyes?	☐	☐
glaucoma?	☐	☐
blurry vision?	☐	☐
halos around lights?	☐	☐
change in vision?	☐	☐

Date of last exam and Doctor's Name

____

D. ENT

Do you have:		
any trouble hearing?	☐	☐
ringing or buzzing in your ears?	☐	☐
earaches or discharge from your ears?	☐	☐
a lot of nasal stuffiness?	☐	☐
drainage down the back of your throat?	☐	☐
frequent or severe nosebleeds?	☐	☐
persistent hoarseness?	☐	☐
a lump in your throat?	☐	☐
a sore tongue or mouth?	☐	☐
bleeding gums?	☐	☐

Date of last dentist visit and Dentist's Name

____

E. Respiratory

Do you have:		
frequent chest colds?	☐	☐
a constant or bothersome cough?	☐	☐
sputum or phlegm between colds?	☐	☐
blood in your sputum?	☐	☐
difficulty breathing?	☐	☐
daytime somnolence?	☐	☐
Have you noticed any wheezing or whistling in your chest?	☐	☐
Do you:		
stop breathing at night?	☐	☐
awake choking?	☐	☐
snore?	☐	☐
fall asleep while driving?	☐	☐

F. Cardiovascular

	Yes	No
Do you have pain, tightness or pressure in the front or back of your chest?	☐	☐
If yes, is it when walking fast, working hard, or when excited?	☐	☐
Have you ever been told that your electrocardiogram was abnormal?	☐	☐
Do you have swelling of your feet or ankles?	☐	☐
Does your heart ever beat fast or irregularly?	☐	☐
Do you have cramps in the calf muscles when you walk?	☐	☐
Do you ever awaken at night with severe difficulty breathing?	☐	☐
Do your fingers or toes ever get cold, become numb, or get very white or bluish?	☐	☐

G. Gastrointestinal

Have you recently had any change in your eating habits?	☐	☐
Are there any special foods that cause you to have stomach pains, nausea, etc.?	☐	☐
Do you tend to burp a lot?	☐	☐
Have you recently noted any trouble swallowing?	☐	☐
Do you have significant indigestion or heartburn?	☐	☐
Do you have frequent nausea and/or vomiting?	☐	☐
Have you ever vomited blood?	☐	☐
Are you bothered with constipation?	☐	☐
Do you have frequent loose stools or diarrhea?	☐	☐
Do you pass a lot of gas?	☐	☐
Do you have a poor appetite?	☐	☐
Do you ever awaken at night with the feeling of fullness underneath your breast bone?	☐	☐
Have you ever passed blood from your rectum?	☐	☐
Have you ever had black or tarry stools?	☐	☐
Have you noticed any recent changes in your bowel movements?	☐	☐
Do you take laxatives regularly?	☐	☐

Date of last colonoscopy and Doctor's name

____

H. Genitourinary

Do you have:		
any problems with your genitals?	☐	☐
burning or pain when you urinate?	☐	☐
to pass water frequently?	☐	☐
to pass more water than you used to?	☐	☐
trouble passing water?	☐	☐
to get up at night to urinate?	☐	☐
trouble with losing urine when you cough or sneeze?	☐	☐
a problem dribbling urine?	☐	☐
Have you ever passed blood in your urine?	☐	☐
Have you had an operation to prevent pregnancy: (Vasectomy, tubal ligation, etc.?)	☐	☐
Men, do you have prostate gland trouble?	☐	☐
Men, do you have problems with erections?	☐	☐

I. Musculoskeletal

Do you have a problem with back pain?	☐	☐
Does back pain interfere with your work or activities?	☐	☐
Do you have pain in your legs or feet?	☐	☐
Do you have joint pain or stiffness?	☐	☐
Do you have trouble walking or using your hip or knee joints?	☐	☐

J. Central Nervous System

	Yes	No
Do you have frequent or severe headaches?	☐	☐
Do you often have spells of dizziness, faintness or light-headedness?	☐	☐
Have you recently fainted, blacked out or lost consciousness?	☐	☐
Have you ever seen double?	☐	☐
Do you sometimes lose track of what happens around you for a short time?	☐	☐
Do you have trouble remembering recent events?	☐	☐
Do you sometimes lose the ability to speak for a few seconds?	☐	☐
Have you ever had seizures?	☐	☐
Do you have numbness or tingling in your head, arms or legs?	☐	☐
Do you consider yourself a nervous person?	☐	☐
Do you cry a lot for no reason?	☐	☐
Have you ever had an urge to commit suicide?	☐	☐
Do you ever hear voices or see people when no one is around?	☐	☐
Do you ever have a feeling that someone is trying to harm you?	☐	☐

K. Women Only

	Yes	No
Did your menstrual periods start before you were 10?	☐	☐
Did your menstrual periods start after you were 15?	☐	☐
Are your menstrual periods irregular?	☐	☐
Are your periods less frequent than every four weeks?	☐	☐
Are your periods more frequent than every four weeks?	☐	☐
Do you pass clots with your periods?	☐	☐
Do you become bloated or gain weight just before your periods?	☐	☐
Have you passed the menopause or change?	☐	☐
Do you have hot flashes?	☐	☐
Have you had any abortions or miscarriages?	☐	☐
Have you ever used an intrauterine device (IUD)?	☐	☐
Have you used other birth control measures?	☐	☐
Have you had any lumps in your breast?	☐	☐
Have you had any discharge from your nipples?	☐	☐

Date of your last Pap Smear ____________________

Name of gynecologist ____________________

Date of last mammogram ____________________

ADDITIONAL COMMENTS

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