

# PATIENT'S PERSONAL HISTORY

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					Sex	Marital Status		Religion
Insurance Company				Insurance No.		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				

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

Stroke _____	Congenital Heart _____	Stomach Ulcers _____	Arthritis _____
High Blood Pressure _____	Parkinson _____	Colitis _____	Bleeding Tendency _____
Diabetes _____	Epilepsy Seizures _____	Tuberculosis _____	Cancer _____
Rheumatic Heart _____	Migraine _____	Asthma _____	Mental Illness _____
Heart Attack _____	Multiple Sclerosis _____	Kidney Disease _____	Suicide _____
		Goiter _____	

**PERSONAL HABITS:** (Circle)

Yes No Do you use tobacco? Cigarettes  Chew  Cigars  For how many years? \_\_\_\_\_ How much? \_\_\_\_\_

Yes No Do you usually drink caffeinated beverages? How much? \_\_\_\_\_ How often? \_\_\_\_\_

Yes No Do you drink alcohol? How much? \_\_\_\_\_ How often? \_\_\_\_\_

Yes No Do you have difficulty in falling asleep?

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

**MEDICATIONS:**

<u>Medication Name</u>	<u>Dose</u>	<u>How often taken</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name any drugs to which you are allergic and the reaction you had:

\_\_\_\_\_

\_\_\_\_\_

List the names of any diseases you had which required hospitalization:

\_\_\_\_\_

\_\_\_\_\_

Other diagnosis (high blood pressure, diabetes, asthma, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Serious injuries or accidents:

\_\_\_\_\_

\_\_\_\_\_

**Please answer the following questions focusing on the past 12 months:**

**GENERAL HEALTH:**

- Y N Have you experienced a change in weight? Intentional / unintentional
- Y N Are you able to perform usual daily activities without difficulty?
- Y N Have you had any recent fevers or unexplained illnesses?
- Y N Have you experienced increasing fatigue or loss of energy?

HEAD/EYES/EARS/NOSE/THROAT

- Y N Have you had episodes of dizziness? Spinning sensation / lightheadedness.
  - Y N Have you had any episodes of fainting or loss of consciousness?
  - Y N Have you experienced any change in vision? Partial loss / Blurred / Double.  
How long did visual problem last? \_\_\_\_\_
  - Y N Have you experienced new onset or increasing neck pain or stiffness?
  - Y N Have you had drooping of one side of your face or of one eye?
  - Y N Do you have severe headaches? How often do they occur? \_\_\_\_\_
- (IF YES ANSWER THE FOLLOWING)
- Y N Do they start with or cause visual problems?
  - Y N Do they occur on one side of the head?
  - Y N Are they associated with: (circle any that apply) nausea / vomiting / sensitivity to light / sound?
  - Y N Are they associated with runny nose or watering eye?
  - Y N Are they relieved with over-the-counter (OTC) medications?  
How frequently do you use OTC meds? \_\_\_\_\_  
Where are headaches most painful? \_\_\_\_\_
- 

CARDIOVASCULAR

- Y N Do you have a history of heart disease or heart attack?
  - Y N Have you experienced palpitations or irregular heart beats?
  - Y N Do you have a history of elevated Blood Pressure?
  - Y N Do you have a history of elevated cholesterol?
  - Y N Do you experience pain in your calves after walking a specific distance that resolves with rest?
- 

RESPIRATORY

- Y N Have you experienced shortness of breath with activity? At rest?
  - Y N Have you coughed up blood or had blood in the sputum?
- 

MUSCULOSKELETAL

- Y N Have you experienced weakness in arms or legs?
  - Y N Have you had loss of muscle mass (not due to lack of exercise)?
  - Y N Are you experiencing loss of motion in any joint? Where: \_\_\_\_\_
  - Y N Are any of your joints becoming increasingly painful? Which one: \_\_\_\_\_
  - Y N Do you have a history of back pain? Neck / Mid / Low How long: \_\_\_\_\_
- 

GASTROINTESTINAL

- Y N Have you experienced any recent changes in appetite?
  - Y N Have you had any difficulty with swallowing?
  - Y N Have you experienced frequent nausea or vomiting?
  - Y N Have you had any changes in bowel habits? Constipation / Diarrhea / Incontinence
- 

NEUROLOGIC

- Y N Do you have a history of seizures or staring spells?
  - Y N Do you have a history of tremors?
  - Y N Have you had any numbness or tingling? Where: \_\_\_\_\_
  - Y N Do you have a history of stroke or "Mini stroke"?
  - Y N Are you experiencing difficulties with walking or change in your gait?
  - Y N Do you have any difficulty with speech or finding / remembering words?
- 

GENITOURINARY

- Y N Have you experienced unexplained incontinence or loss of bladder function?
  - Y N Do you experience pain / tingling with urination?
  - Y N Do you have a history of kidney stones?
- Females:**
- Y N Do you have regular menstrual cycles? When was your last period? \_\_\_\_\_
  - Y N Do you now take birth control pills or have you ever taken birth control?
  - Y N Do you have a history of a miscarriage?  
List any complications of pregnancy \_\_\_\_\_
- Males:**
- Y N Have you had any loss of sexual activity or erectile dysfunction?
  - Y N Have you experienced any urethral discharge or sores on the penis?

