

PATIENT'S PERSONAL HISTORY FORM

NOTE: This is a confidential record and will be kept in this facility or in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Name _____ Age _____ Date _____

Occupation _____ Birth Place _____ Birth Date _____

Dr. _____ Date of last Physical Examination _____

List all States and Countries in which you have live: _____

Chief Complaints: (Please list all symptoms.)

1. _____ 3. _____

2. _____ 4. _____

Please answer each of the following questions by placing an (X) in the "YES" box if your answer to the question is yes, or by placing an (X) in the "NO" box if your answer to the question is no. Fill in "who" and "when" information when necessary.

FAMILY HISTORY

Has any blood relative ever had any of the following? (Check all that apply):

- | | | | |
|----------------------------|--|------------------------------------|---|
| Cancer, including Leukemia | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | Other Anemia | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ |
| Tuberculosis | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | Mental Illness | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ |
| Diabetes | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | Suicide | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ |
| Heart Trouble | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | Birth Defects | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ |
| Heart Attack | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | Other Serious Disease | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ |
| High Blood Pressure | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | Do you Smoke? | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Stroke | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | If Yes, What _____ How Much? _____ | |
| Epilepsy | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | Did your parents smoke? | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ |
| Bleeding Disorder | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | Do you drink? | |
| Asthma | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | Beer | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Allergies | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | Wine | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Liver Disease | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | Other Alcoholic Beverages | <input type="checkbox"/> NO <input type="checkbox"/> YES WHAT _____ |
| Migraine Headaches | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | How much of each? _____ | |
| Alcoholism | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | Are you on a special diet? | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Emphysema | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | What diet? _____ | |
| Stomach or Duodenal Ulcer | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | | |
| Kidney Disease | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | | |
| Glaucoma | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | | |
| Sickle Cell Anemia | <input type="checkbox"/> NO <input type="checkbox"/> YES WHO _____ | | |

	AGE	LIVING	DEAD	AGE AT DEATH	CAUSE OF DEATH
Father					
Mother					
Brother or Sister					
Husband or Wife					
Son or Daughter					

PERSONAL HISTORY (continued)

Have you lost weight in the past year? NO YES
 Do you have difficult sleeping? NO YES
 Are you overweight? NO YES

X-RAYS

Have you had any of these X-Rays?
 If so, when?

Chest NO YES WHEN _____
 Stomach NO YES WHEN _____
 Colon NO YES WHEN _____
 Gall Bladder NO YES WHEN _____
 Back NO YES WHEN _____
 Kidney NO YES WHEN _____
 Extremities NO YES WHEN _____
 Other NO YES WHEN _____
 Have you ever had x-ray treatment? NO YES WHEN _____

IMMUNIZATIONS

Have you ever been immunized against:

Small Pox NO YES LAST SHOT _____
 Tetanus NO YES LAST SHOT _____
 Polio (shots or oral vaccine) NO YES LAST SHOT _____
 Measles NO YES LAST SHOT _____
 German measles NO YES LAST SHOT _____
 Other _____ NO YES LAST SHOT _____

ALLERGIES

Are you allergic to any of the following?

Penicillin NO YES
 Sulfa NO YES
 Other antibiotics NO YES WHAT _____
 Any other drugs or medicine NO YES WHAT _____
 Any food NO YES WHAT _____
 Nail polish or cosmetics NO YES WHAT _____
 Other _____ NO YES

MEDICINES

Are you taking any medicines Regularly now? NO YES WHAT _____

MEDICINES (Continued)

Have you ever taken:
 Insulin NO YES WHEN _____
 Cortisone NO YES WHEN _____
 Thyroid Medicine NO YES WHEN _____
 Male or female hormones NO YES WHEN _____
 Blood pressure medicine NO YES WHEN _____
 Tranquilizers or sedatives NO YES WHEN _____
 Birth control pills NO YES WHEN _____
 Other NO YES WHEN _____

DEVICES

Do you use:
 Eyeglasses NO YES
 Contact lenses NO YES
 Hearing aid NO YES
 Dentures NO YES
 Neck brace NO YES
 Back brace NO YES
 Other brace NO YES WHAT _____
 Artificial limb NO YES
 Truss NO YES
 Pacemaker NO YES
 I. U. D. NO YES
 Diaphragm NO YES
 Other device NO YES WHAT _____

OPERATIONS

Have you had any of these operated upon:

Tonsils NO YES WHEN _____
 Appendix NO YES WHEN _____
 Gall Bladder NO YES WHEN _____
 Stomach NO YES WHEN _____
 Small intestine NO YES WHEN _____
 Kidney NO YES WHEN _____
 Colon NO YES WHEN _____
 Thyroid NO YES WHEN _____
 Hernia NO YES WHEN _____
 Other _____ NO YES WHEN _____
WOMEN
 Breast NO YES WHEN _____
 Ovaries NO YES WHEN _____
 Uterus NO YES WHEN _____
MEN
 Prostate NO YES WHEN _____

DIAGNOSED DIFFICULTIES

Do you now or have you in the past, had any of the following:

Migraine headaches	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Epilepsy or convulsions	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Stroke	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Glaucoma	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Cataracts	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Blindness either eye	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Ear infections	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Deafness	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Asthma	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Hay fever	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Chronic bronchitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Emphysema	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Tuberculosis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Abnormal chest x-ray	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Heart murmur as an adult	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Abnormal electrocardiogram	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Enlarged heart	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Heart attack	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Rheumatic fever	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Angina	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
High blood pressure	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Gall stones	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Hepatitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Cirrhosis of liver	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Stomach or duodenal ulcer	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Abnormal stomach x-ray	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____

DIAGNOSTED DIFFICULTIES (continued)

Colon or bowel trouble	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Rectal trouble	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Hemorrhoids or piles	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Dysentery or serious diarrhea	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Kidney or bladder infection	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Kidney stones	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Other kidney disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
What? _____				
Anemia	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
What kind? _____				
Poor blood clotting	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Diabetes	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
On insulin?	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
How much? _____				
Gout	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Overactive thyroid	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Under active thyroid	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Goiter	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Broken Bones	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Varicose veins	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Arthritis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Polio	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Phlebitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Syphilis or V.D.	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Gonorrhea	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
HIV/AIDS	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Recurrent boils	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Other skin disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
What kind? _____				
Serious depression	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Serious emotional problem	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Nervous breakdown	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
WOMEN				
Menstrual difficulties	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Ovarian cyst	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Other GYN problems	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
What kind? _____				
Age periods started _____				
Still menstruating	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
Age periods stopped _____				
Why periods stopped _____				
Are your periods regular	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
Cystitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Mastitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Breast Cancer	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Other breast disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
What kind? _____				
Number of times pregnant _____				
Number of children _____				
Number of miscarriages _____				
MEN				
Prostate trouble	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Other illness	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
What kind? _____				

DO YOU HAVE ANY OF THE FOLLOWING COMPLAINTS:

GENERAL			HEAD (continued)		
Fever	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Ear pain	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Chills	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Drainage from ear	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Aches and pains	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Hearing difficulty or deafness	<input type="checkbox"/> NO	<input type="checkbox"/> YES
General headaches	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Buzzing or ringing in ears	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Memory loss	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Nosebleeds not due to injury	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Swollen Glands	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Sinus trouble	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Easy bruising	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Difficulty swallowing	<input type="checkbox"/> NO	<input type="checkbox"/> YES
HEAD			Mouth, tooth, or tongue problem	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Blurred vision not corrected			Persistent hoarseness	<input type="checkbox"/> NO	<input type="checkbox"/> YES
By glasses	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Severe headaches	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Double vision	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Other _____	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Light flashes	<input type="checkbox"/> NO	<input type="checkbox"/> YES			
Halos around lights	<input type="checkbox"/> NO	<input type="checkbox"/> YES			
Pain in your eyes	<input type="checkbox"/> NO	<input type="checkbox"/> YES			

SKIN
 Changing mole NO YES
 Rash NO YES
 Yellow Skin NO YES
 Other skin problem NO YES
 What is it? _____

NECK
 Swelling NO YES
 Lumps NO YES
 Stiffness NO YES
 Other _____ NO YES

CHEST, HEART, LUNGS
 Shortness of breath NO YES
 Poor exercise tolerance NO YES
 Fluttering of heart NO YES
 Unusual heartbeat NO YES
 Chest pain or pressure attacks NO YES
 Frequent cough NO YES
 Coughing up blood NO YES
 Wheezing NO YES
 Night sweats NO YES
 Swollen ankles NO YES
 Leg cramps NO YES
 Other _____ NO YES

GASTROINTESTINAL
 Poor appetite NO YES
 Indigestion or heartburn NO YES
 Difficulty swallowing NO YES
 Nausea or vomiting NO YES
 Vomiting blood NO YES
 Abdominal pain or cramps NO YES
 Abdominal swelling NO YES
 Diarrhea NO YES
 Constipation NO YES
 Change in bowel habits NO YES
 Pass blood from rectum NO YES
 Black, tar-like bowel
 Movements NO YES
 Other _____ NO YES

ENDOCRINE
 Thirsty all the time NO YES
 Cold most of the time NO YES
 Too warm most of the time NO YES
 Unusually tired or sluggish NO YES
 Unusually jumpy or nervous NO YES

NEUROMUSCULAR
 Weakness in arm or leg NO YES
 Difficulty with balance NO YES
 Dizzy spells NO YES
 Fainting spells NO YES
 Speech difficulty NO YES
 Other _____ NO YES

BONES-JOINTS
 Painful joints NO YES
 Swollen joints NO YES
 Loss of muscle strength NO YES
 Lump or swelling in muscle NO YES
 Lump on bone NO YES
 Back pain NO YES
 Other _____ NO YES

KIDNEY
 Blood in urine NO YES
 Pain or burning while urinating NO YES
 Difficulty passing urine NO YES
 Getting up at night to urinate NO YES
 Other _____ NO YES

GENITALIA
 WOMEN
 Breast lump NO YES
 Discharge from nipple NO YES
 Other breast problem NO YES
 What is it? _____
 Vaginal discharge NO YES
 Vaginal bleeding or spotting
 (not with periods) NO YES
 Hot flashes NO YES
 Pain with intercourse NO YES
 Possibly pregnant NO YES
 Change in periods NO YES
 Pain not associated with periods NO YES
 Other _____ NO YES

MEN
 Breast lump NO YES
 Discharge from penis NO YES
 Sore on penis NO YES
 Lump in testicles NO YES
 Difficulty having erections NO YES
 Other _____ NO YES

PSYCHOLOGICAL
 Do you find you life:
 Generally unsatisfactory NO YES
 Too demanding NO YES
 Boring NO YES
 Satisfactory NO YES

Do you worry about:
 Money NO YES
 Job NO YES
 Marriage NO YES
 Home life NO YES
 Children NO YES

Do you:
 Cry easily NO YES
 Feel inferior to others NO YES
 Feel shy NO YES
 Feel things often go wrong NO YES
 Often feel depressed NO YES
 Have irrational fears NO YES
 Feel anxious or upset NO YES

Have you:
 Seriously considered suicide NO YES
 Attempted suicide NO YES