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 ______________ Date of Birth ______________

Doctor ______________________ Date of Last Physical Evaluation ______________________

List all States and Countries in which you have lived ______________________________

Chief Complaints: (please list all symptoms)

1. ______________________
2. ______________________
3. ______________________
4. ______________________

FAMILY HISTORY: Has any blood relative ever had any of the following?

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.

Condition			
Cancer, including Leukemia	☐ No	☐ Yes	Who ________
Tuberculosis	☐ No	☐ Yes	Who ________
Diabetes	☐ No	☐ Yes	Who ________
Heart Trouble	☐ No	☐ Yes	Who ________
Heart Attack	☐ No	☐ Yes	Who ________
High Blood Pressure	☐ No	☐ Yes	Who ________
Stroke	☐ No	☐ Yes	Who ________
Epilepsy	☐ No	☐ Yes	Who ________
Bleeding Disorder	☐ No	☐ Yes	Who ________
Asthma	☐ No	☐ Yes	Who ________
Migraine Headaches	☐ No	☐ Yes	Who ________
Allergies	☐ No	☐ Yes	Who ________
Liver Disease	☐ No	☐ Yes	Who ________
Alcoholism	☐ No	☐ Yes	Who ________
Emphysema	☐ No	☐ Yes	Who ________
Kidney Disease	☐ No	☐ Yes	Who ________
Glaucoma	☐ No	☐ Yes	Who ________
Sickle Cell Anemia	☐ No	☐ Yes	Who ________
Stomach or Duodenal Ulcer	☐ No	☐ Yes	Who ________
Other Anemia	☐ No	☐ Yes	Who ________
Mental Illness	☐ No	☐ Yes	Who ________
Suicide	☐ No	☐ Yes	Who ________
Birth Defects	☐ No	☐ Yes	Who ________
Other Serious Disease	☐ No	☐ Yes	Who ________

Do you smoke? ☐ No ☐ Yes

If Yes, What? ____________ How Much? ____________

Did your parents smoke? ☐ No ☐ Yes Who ____________

Do you drink? ☐ No ☐ Yes

Beer ☐ No ☐ Yes

Wine ☐ No ☐ Yes

Other Alcoholic Beverages? ☐ No ☐ Yes What? ____________

How much of each? ____________

Are you on a special diet? ☐ No ☐ Yes

What diet? ____________________

How many days per week do you exercise ____________

What type of exercises do you do? ____________

Have you lost weight in the past year? ☐ No ☐ Yes

Do you have difficulty sleeping? ☐ No ☐ Yes

Are you overweight? ☐ No ☐ Yes

Family History

	AGE	LIVING	DEAD	AGE OF DEATH	CAUSE OF DEATH
Paternal Grandfather		☐	☐		
Paternal Grandmother		☐	☐		
Father		☐	☐		
Maternal Grandfather		☐	☐		
Maternal Grandmother		☐	☐		
Mother		☐	☐		
Brother ☐ Sister ☐		☐	☐		
Brother ☐ Sister ☐		☐	☐		
Brother ☐ Sister ☐		☐	☐		
Brother ☐ Sister ☐		☐	☐		
Brother ☐ Sister ☐		☐	☐		
Brother ☐ Sister ☐		☐	☐		
Husband ☐ Wife ☐		☐	☐		
Son ☐ Daughter ☐		☐	☐		
Son ☐ Daughter ☐		☐	☐		
Son ☐ Daughter ☐		☐	☐		
Son ☐ Daughter ☐		☐	☐		
Son ☐ Daughter ☐		☐	☐		
Son ☐ Daughter ☐		☐	☐		

PATIENT'S PERSONAL HISTORY (continued)

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 ____ 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 Foods	☐ No	☐ Yes	What ____
Nail Polish or Cosmetics	☐ No	☐ Yes	What ____

Other ____ What ____

DEVICES: Do you use any of the following devices?

Eyeglasses	☐ No	☐ Yes	
Contact Lenses	☐ No	☐ Yes	
Hearing Aids	☐ 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 ____

MEDICINES: Are you currently taking any medicines regularly?

☐ No ☐ Yes

If YES, what medicines? ____

____

____

Have you ever taken any of these medicines?

Insulin	☐ No	☐ Yes	When ____
Cortisone	☐ No	☐ Yes	When ____
Thyroid Medicine	☐ No	☐ Yes	When ____
Male or Female Hormones	☐ No	☐ Yes	When ____
Blood Pressure Medicines	☐ No	☐ Yes	When ____
Tranquilizers or sedatives	☐ No	☐ Yes	When ____
Birth Control Pills	☐ No	☐ Yes	When ____

Other ____ When ____

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 ____

WOMEN:

Breast	☐ No	☐ Yes	When ____
Ovaries	☐ No	☐ Yes	When ____
Uterus	☐ No	☐ Yes	When ____

MEN:

Prostate	☐ No	☐ Yes	When ____

PATIENT'S PERSONAL HISTORY (continued)

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

Migraine Headaches ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Epilepsy or Convulsions ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Stroke ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Glaucoma ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Cataracts ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Blindness in either eye ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Ear Infections ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Deafness ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Asthma ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Hay Fever ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Chronic Bronchitis ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Emphysema ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Tuberculosis ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Abnormal Chest X-Ray ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Heart Murmur as an adult ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Abnormal Electrocardiogram ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Enlarged Heart ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Heart Attack ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Rheumatic Fever ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Angina ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

High Blood Pressure ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Gall Stones ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Hepatitis ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Cirrhosis of Liver ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Stomach or Duodenal Ulcer ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Abnormal Stomach X-Ray ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Colon or Bowel Trouble ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Rectal Trouble ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Hemorrhoids or piles ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Dysentery or serious diarrhea ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Kidney or Bladder Infection ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Kidney Stones ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Other Kidney Disease? ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

What? ______

Anemia ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

What kind? ______

Poor Blood Clotting ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Gout ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

PATIENT'S PERSONAL HISTORY (continued)

Diabetes ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

On Insulin? ☐ No ☐ Yes

How Much? ______

Overactive Thyroid ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Under active Thyroid ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Goiter ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Broken Bones ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Varicose Veins ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Arthritis ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Polio ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Phlebitis ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Syphilis or V.D. ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Oral or genital herpes ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Gonorrhea ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

HIV/AIDS ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Recurrent Boils ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Other Skin Disease ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

What Kind? ______

Serious Depression ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Serious Emotional Problem ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Nervous Breakdown ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

WOMEN:

Menstrual Difficulties ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Ovarian Cyst ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Other GYN Problems ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

What Kind? ______

Age Periods Started ______

Still Menstruating ☐ No ☐ Yes

Age Periods Stopped ______

Why Periods Stopped ______

Are your periods regular? ☐ No ☐ Yes

Cystitis ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Mastitis ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Breast Cancer ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Other Breast Disease ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

What kind? ______

Number of Children ______ Number of Miscarriages ______ Number of Times Pregnant ______

MEN:

Prostate Trouble ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

Other Illness? ☐ No ☐ Yes, Have Now ☐ Yes, In Past When ______

What Kind? ______

COMPLAINTS: Do you have any of the following complaints?

GENERAL:

- Fever ☐ No ☐ Yes
- Chills ☐ No ☐ Yes
- Aches and Pains ☐ No ☐ Yes
- General Headaches ☐ No ☐ Yes
- Memory Loss ☐ No ☐ Yes
- Swollen Glands ☐ No ☐ Yes
- Easy Bruising ☐ No ☐ Yes

HEAD:

- Blurred Vision (not corrected) ☐ No ☐ Yes
  - By glasses ☐ No ☐ Yes
- Double Vision ☐ No ☐ Yes
- Light Flashes ☐ No ☐ Yes
- Halos around lights ☐ No ☐ Yes
- Pain in your eyes ☐ No ☐ Yes
- Ear Pain ☐ No ☐ Yes
- Drainage from ear ☐ No ☐ Yes
- Hearing Difficulty or Deafness ☐ No ☐ Yes
- Buzzing or Ringing in ears ☐ No ☐ Yes
- Nosebleeds (not from injury) ☐ No ☐ Yes
- Sinus Trouble ☐ No ☐ Yes
- Difficulty swallowing ☐ No ☐ Yes
- Mouth, Tooth, or Tongue problem ☐ No ☐ Yes
- Persistent Hoarseness ☐ No ☐ Yes
- Severe Headaches ☐ No ☐ Yes

Other ______________________________

SKIN:

- Changing Mole ☐ No ☐ Yes
- Rash ☐ No ☐ Yes
- Yellow Skin ☐ No ☐ Yes
- Other Skin Problems? ☐ No ☐ Yes

What is it? ______________________________

NECK:

- Swelling ☐ No ☐ Yes
- Lumps ☐ No ☐ Yes
- Stiffness ☐ No ☐ Yes

Other ______________________________

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 ______________________________

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 ______________________________

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

Other ______________________________

COMPLAINTS (continued)

NEUROMUSCULAR:

Weakness in arms or legs	☐ No	☐ Yes
Difficulty with balance	☐ No	☐ Yes
Dizzy spells	☐ No	☐ Yes
Fainting spells	☐ No	☐ Yes
Speech difficulty	☐ No	☐ Yes

Other ______________________________

BONE-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 ______________________________

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 ______________________________

GENITALIA:

WOMEN:

Breast Lump	☐ No	☐ Yes
Discharge from nipple	☐ No	☐ Yes
Other breast problem	☐ No	☐ Yes

What? ______________________________

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 ______________________________

PSYCHOLOGICAL:

Do you find 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

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 ______________________________

CHIEF COMPLAINTS: Please complete the sections below for each disease or symptom you are currently experiencing. Beginning with Section 1, list the diseases or symptoms in the order of importance or severity.

1) Symptom or Disease: ____________________

When did and symptoms start? ____________________

How often do you experience symptoms? (*Please check one*) ☐ Daily ☐ Every Other Day ☐ 2 - 3 Times a Week ☐ Weekly ☐ Monthly

Other ____________________

How long do the episodes last? ____________________

Have you seen another physician regarding this? ☐ Yes ☐ No

If yes, who and what specialty? ____________________

What tests did you have done? ____________________

____

If so, what treatment was prescribed? ____________________

Please list any medications you have taken for these symptoms/this disease: ____________________

____

Have you had any side effects or other problems with these medications? *(ineffective, etc)* ☐ Yes ☐ No

If so, what medication was it and what was the side effect or result from that medication? *(Please list all)* ____________________

____

____

____

2) Symptom or Disease: ____________________

When did and symptoms start? ____________________

How often do you experience symptoms? (*Please check one*) ☐ Daily ☐ Every Other Day ☐ 2 - 3 Times a Week ☐ Weekly ☐ Monthly

Other ____________________

How long do the episodes last? ____________________

Have you seen another physician regarding this? ☐ Yes ☐ No

If yes, who and what specialty? ____________________

What tests did you have done? ____________________

____

If so, what treatment was prescribed? ____________________

Please list any medications you have taken for these symptoms/this disease: ____________________

____

Have you had any side effects or other problems with these medications? *(ineffective, etc)* ☐ Yes ☐ No

If so, what medication was it and what was the side effect or result from that medication? *(Please list all)* ____________________

____

____

____

CHIEF COMPLAINTS (continued)

3) Symptom or Disease: ______

When did and symptoms start? ______

How often do you experience symptoms? (*Please check one)* ☐ Daily ☐ Every Other Day ☐ 2 - 3 Times a Week ☐ Weekly ☐ Monthly

Other ______

How long do the episodes last? ______

Have you seen another physician regarding this? ☐ Yes ☐ No

If yes, who and what specialty? ______

What tests did you have done? ______

______

If so, what treatment was prescribed? ______

Please list any medications you have taken for these symptoms/this disease: ______

______

Have you had any side effects or other problems with these medications? *(ineffective, etc)* ☐ Yes ☐ No

If so, what medication was it and what was the side effect or result from that medication? *(Please list all)* ______

______

______

______

4) Symptom or Disease: ______

When did and symptoms start? ______

How often do you experience symptoms? (*Please check one)* ☐ Daily ☐ Every Other Day ☐ 2 - 3 Times a Week ☐ Weekly ☐ Monthly

Other ______

How long do the episodes last? ______

Have you seen another physician regarding this? ☐ Yes ☐ No

If yes, who and what specialty? ______

What tests did you have done? ______

______

If so, what treatment was prescribed? ______

Please list any medications you have taken for these symptoms/this disease: ______

______

Have you had any side effects or other problems with these medications? *(ineffective, etc)* ☐ Yes ☐ No

If so, what medication was it and what was the side effect or result from that medication? *(Please list all)* ______

______

______

______

CHIEF COMPLAINTS (continued)

5) Symptom or Disease: ____________________

When did and symptoms start? ____________________

How often do you experience symptoms? (*Please check one*) ☐ Daily ☐ Every Other Day ☐ 2 - 3 Times a Week ☐ Weekly ☐ Monthly

Other ____________________

How long do the episodes last? ____________________

Have you seen another physician regarding this? ☐ Yes ☐ No

If yes, who and what specialty? ____________________

What tests did you have done? ____________________

____

If so, what treatment was prescribed? ____________________

Please list any medications you have taken for these symptoms/this disease: ____________________

____

Have you had any side effects or other problems with these medications? *(ineffective, etc)* ☐ Yes ☐ No

If so, what medication was it and what was the side effect or result from that medication? *(Please list all)* ____________________

____

____

____

6) Symptom or Disease: ____________________

When did and symptoms start? ____________________

How often do you experience symptoms? (*Please check one*) ☐ Daily ☐ Every Other Day ☐ 2 - 3 Times a Week ☐ Weekly ☐ Monthly

Other ____________________

How long do the episodes last? ____________________

Have you seen another physician regarding this? ☐ Yes ☐ No

If yes, who and what specialty? ____________________

What tests did you have done? ____________________

____

If so, what treatment was prescribed? ____________________

Please list any medications you have taken for these symptoms/this disease: ____________________

____

Have you had any side effects or other problems with these medications? *(ineffective, etc)* ☐ Yes ☐ No

If so, what medication was it and what was the side effect or result from that medication? *(Please list all)* ____________________

____

____

____