

Patient Personal History Form

Name: _____ Date: ___/___/___

Birth date: ___/___/___

Primary Physician: _____

States/ Countries you have lived _____

Reason for the visit (symptoms)

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Social History:

Occupation _____

Smoking Y N
 Pack./day ___
 Quit y/n year__

Alcohol Y N
 Drinks/wk. ___

Caffeine Y N
 Cups/day _____

Family History (please indicate relationship ie. mother, sister ect.)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Illness (depression/ anxiety/other) |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcohol or Drug addiction | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Type |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Heart Disease | | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Stroke | | | |

Medical History

Medical Conditions: (e.g. diabetes, high blood pressure, etc.)

_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS: (Include: allergy shots, birth control,pain control, laxatives, vitamins, diet pills, antidepressants, inhalers, etc.)Include dose and how often you take it.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SURGERIES : (include dates or age at the time, conditions)

_____	_____
_____	_____
_____	_____

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ALLERGIES: (Medications, foods, insects, latex)

Conditions / Symptoms: (Circle those you currently have)

General

- Decreased hearing
- Ringing in ear
- Dizzy spells
- Fainting spells
- Vision problems
- Sinus trouble
- Other:

Lung / Heart

- Pneumonia
- Bronchitis
- Asthma
- Shortness of breath:
 - on exertion
 - lying flat
- Angina
- High blood pressure
- Heart murmur
- Swollen ankles
- Palpitations
- Leg pain
 - when walking
- High cholesterol
- Other:

Gastrointestinal

- Weight-loss
- Weight gain
- Loss of appetite
- Difficulty swallowing
- Heartburn
- Persistent nausea / vomiting
- Abdominal pain
- Jaundice / Hepatitis
- Diarrhea
- Constipation
- Bloody or tarry stools
- Other:

Kidney / Bladder

- Frequent or painful urination
- Blood in urine
- Kidney stones
- Urine infections
- Sexually transmitted disease
- Other:

Blood

- Anemia
- Bruise easily
- Blood transfusions
- Chronic fatigue
- Other:

Endocrine

- Diabetes
- Thyroid disease
- Other

Skin

- Rashes
- Skin cancer
- Other:

Neuro-/psychological

- Seizures
- Stroke
- Tremors
- Numbness / tingling
- Headaches
- Head injury
- Alcohol / drug addiction
- Eating disorder
- Depression
- Anxiety
- Suicide attempt
- Psychiatric disorder
- Other

Musculo/skeletal

- Arthritis
- Back pain / injury
- Fractured bone
- Other

MALES:

- Difficult erections
- Undescended testicle,
- Testicular mass, lump
- Other:

FEMALES:

- Menstrual periods:
 - Reg. Irreg.
 - Number of:
 - Pregnancies ____
 - Abortions ____
 - Miscarriages ____
 - Live births ____
- Hysterectomy
- Breast lumps
- Breast cancer

Signature: _____

Date: _____