

PATIENT'S PERSONAL HISTORY

Patient No.: _____

Please bring your insurance card and medications with you on your appointment date.

Appointment Date: _____

Confidential Record: Information contained here will not be released except when you authorize us to do so.

Last Name		First	Middle	Birth Date		Age
Address		City	State	Zip	Home Phone	
Social Security Number		Employer Name			Business Phone/Occupation	
Insurance Company		Insurance Number			Sex	Marital Status
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> S
Emergency Contact: _____				Relationship: _____		
Address: _____				Phone Number: _____		
Date of Last Examination: _____				Doctor: _____		
Family or Referring Physician: _____				Address: _____		

Reason for Today's Visit: _____

PAST MEDICAL HISTORY:

High Blood Pressure N _____ Y _____
 Diabetes N _____ Y _____
 High Cholesterol N _____ Y _____
 Other _____
 Other _____
 Other _____
 Other _____

PAST SURGICAL HISTORY:

Coronary Bypass N _____ Y _____
 Heart Valve Surgery N _____ Y _____
 Pacemaker/Defibrillator N _____ Y _____
 Stents/Angioplasty N _____ Y _____
 Other _____
 Other _____
 Other _____

Please List Allergies Below:

FAMILY HISTORY:

	Age	Sex	Medical Problems	If Deceased...	
				Age at Death	Cause
Father					
Mother					
Brothers / Sisters					
Children					

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

Stroke: _____ Cancer: _____ High Blood Pressure: _____

Diabetes: _____ Heart Disease: _____ High Cholesterol: _____

MEDICATIONS (prescription and non-prescription):

We highly recommend that you bring all your pill bottles (including over the counter drugs) to the visit. Otherwise, please list all the medications, strength, and number taken below.

	Medication Name	Dosage	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

Please list additional medications on the back page.

Vitamins? N _____ Y _____ Please List _____

Herbs (eg. teas/drinks)? N _____ Y _____ Please List _____

Oral Contraceptives? N _____ Y _____

Occupation: _____ Employer: _____

Retired

Disabled

Tobacco Use N ____ Y ____ Amount _____ How Long _____ Yr. Stopped: _____

Alcohol Use N ____ Y ____ Type _____ Quantity _____ Frequency _____

Illicit Drug Use N ____ Y ____ Type _____ How Long? _____ Frequency _____

Coffee Use N ____ Y ____ Amount _____ How Long? _____ Frequency _____

Tea Use N ____ Y ____ Amount _____ How Long? _____ Frequency _____

Soft Drinks N ____ Y ____ Amount _____ How Long? _____ Frequency _____

Exercise Regularly? N ____ Y ____ What Kind? _____ How Often? _____

REVIEW OF SYSTEMS:

Have you **recently** had any of the following problems? (*Please check all that apply.*)

Constitutional	Skin	Gastrointestinal	Genitourinary	Ear/Nose/Mouth/ Throat
<input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Major Weight Change <input type="checkbox"/> Appetite Loss <input type="checkbox"/> Snoring <input type="checkbox"/> Stop Breathing During Sleep <input type="checkbox"/> Sleep on More than 1 Pillow	<input type="checkbox"/> Rash <input type="checkbox"/> Itch <input type="checkbox"/> Ulcers on Feet <input type="checkbox"/> Unexplained Hair Loss	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Heartburn <input type="checkbox"/> Mucous in the Stool <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Ribbon-like Stool	<input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Painful Urination <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Urinate More Than Twice At Night	<input type="checkbox"/> Ear Infection <input type="checkbox"/> Sore Throat <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Hoarseness
Cardiovascular	Respiratory	Musculoskeletal	Hematologic/ Lymphatic	Eyes
<input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> [] Controlled <input type="checkbox"/> [] Uncontrolled <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Swelling in Ankles/Feet	<input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> [] With Exertion <input type="checkbox"/> [] Without Exertion <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema	<input type="checkbox"/> Joint Pain <input type="checkbox"/> Neck Pain <input type="checkbox"/> Back Pain <input type="checkbox"/> Leg/Hip Pain When Walking	<input type="checkbox"/> Swollen Glands <input type="checkbox"/> Blood Clotting Problems <input type="checkbox"/> Unexplained Bruising	<input type="checkbox"/> Blurred Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Eye Pain <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma
Neurological	Allergic / Immunologic	Psychological	Endocrine	
<input type="checkbox"/> Tremors <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Arm / Leg Weakness	<input type="checkbox"/> Allergies <input type="checkbox"/> Hay Fever	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Unusual Stress <input type="checkbox"/> Eating Order <input type="checkbox"/> Attempt Suicide	<input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Cold Intolerance	
For MEN	Give date of last...	For WOMEN	Give date of last...	
Prostate Exam ____/____/____	PSA ____/____/____	Menstruation ____/____/____	Pap Smear ____/____/____	
____ Difficulty with Erections		Breast Exam ____/____/____	#of Pregnancies _____	

Date of last: Pneumovax ____/____/____ Flu Shot ____/____/____ Tetanus ____/____/____ Colonoscopy ____/____/____

Patient's Signature _____ Date _____ Physician Signature _____

