

PATIENT'S PERSONAL HISTORY

DATE: _____

Confidential Record: Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in decisions regarding your care.

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

AGE: _____ HT: _____ WT: _____ SEX: M F MARITAL STATUS: S M W D or Separated

PREVIOUS OR REFERRING PHYSICIAN: _____ PHONE: _____

DO YOU HAVE OR HAVE YOU HAD: (CIRCLE – IF YES, GIVE DATE OF OCCURRENCE)

Stroke	No	Yes _____	Migraine	No	Yes _____	Congenital Heart	No	Yes _____
Cancer	No	Yes _____	High Fever	No	Yes _____	Rheumatic Heart	No	Yes _____
Tuberculosis	No	Yes _____	Colitis	No	Yes _____	Bleeding Tendency	No	Yes _____
Diarrhea	No	Yes _____	Asthma	No	Yes _____	High Blood Pressure	No	Yes _____
Bronchitis	No	Yes _____	Heart Attack	No	Yes _____	Thyroid Problems	No	Yes _____
Seizures	No	Yes _____	Tonsillitis	No	Yes _____	Anxiety or Depression	No	Yes _____
Pneumonia	No	Yes _____	Heart Failure	No	Yes _____	Bladder Infection	No	Yes _____
Diabetes	No	Yes _____	AIDS/+HIV	No	Yes _____	Stomach Ulcers	No	Yes _____
Arthritis	No	Yes _____	Glaucoma	No	Yes _____	Kidney Disease	No	Yes _____
Gall Stones	No	Yes _____	Blood Clots	No	Yes _____	High Cholesterol	No	Yes _____

Write in the names and years of any surgeries you have had: _____

Please list any medications you are taking with the amount and frequency: (Including non-prescription drugs)

Name any drug allergies: _____

Name any serious illnesses you have had: _____

Name any serious injuries or accidents you have had: _____

DO YOU USE TOBACCO PRODUCTS? NO YES HOW MUCH? _____

DO YOU REGULARLY DRINK ALCOHOL, WINE, OR BEER? NO YES HOW MUCH? _____

DO YOU KNOW OF ANY BLOOD RELATIVE WHO HAS OR HAD: (Circle and give relationship)

Stroke	No	Yes _____	Epilepsy/Seizure	No	Yes _____
Breast Cancer	No	Yes _____	Suicide	No	Yes _____
Cancer	No	Yes _____	Migraine Headaches	No	Yes _____
High Blood Pressure	No	Yes _____	Asthma	No	Yes _____
Tuberculosis	No	Yes _____	Bleeding Tendency	No	Yes _____
Diabetes	No	Yes _____	Heart Attack	No	Yes _____
Leukemia	No	Yes _____	Kidney Disease	No	Yes _____
Stomach Ulcers	No	Yes _____	Arthritis	No	Yes _____
Thyroid Disease	No	Yes _____	Depression	No	Yes _____
Colitis	No	Yes _____	High Cholesterol	No	Yes _____
Rheumatic Heart	No	Yes _____	Hay Fever	No	Yes _____
Congenital Heart	No	Yes _____	Back or Neck Problems	No	Yes _____
High fever after surgery	No	Yes _____	Other	No	Yes _____