PMG#_____

PREMIER MEDICAL GROUP

Personal History Form

NAME:_____ AGE:_____ MARITAL STATUS: S M W D

OCCUPATION:_____ EDUCATION:_____

Have you lived or traveled outside the U.S. or Canada in the last 3 months? ☐ Yes ☐ No

When was your last medical check up? Date_____ By whom? _____ M.D.

	Living	Age/age at death	Present health/cause of death
Mother	Yes No		
Father	Yes No		
Spouse	Yes No		
	# living	**# dead**	**Health/cause of death/age at death**
Brothers			
Sisters			
Children			

CIRCLE ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES:

Bleeding tendency Kidney disease Tuberculosis/+ skin test Diabetes Cancer Heart disease
High blood pressure Nervous illness Sickle cell Allergy/Asthma

CIRCLE ILLNESSES OR CONDITIONS YOU HAVE HAD:

High blood pressure Mononucleosis Heart trouble Lung disease Thyroid trouble Venereal Disease
Vein trouble Kidney disease Arthritis Diabetes Bleeding tendencies Nervous disorder
Cancer Jaundice/liver disease Tuberculosis/+ skin test Digestive/Intestinal disorders/ulcers
Seizure disorder Allergy/Asthma Are you or have you been medically disabled? ☐ Yes ☐ No

LIST ANY HOSPITALIZATIONS OR SURGERY:

Operations:_____

CHECK THE DISEASE AGAINST WHICH YOU HAVE BEEN IMMUNIZED: give dates

Flu_____ Pneumovax_____ Measles_____ Polio_____ Hepatitis B_____ Tetanus_____

Are you allergic/intolerant to any drugs, foods or other products? Please list:

_____

_____

SOCIAL HISTORY:

Do you smoke: ☐ Now ☐ In the past # of years_____ ☐ Never
☐ Cigarettes ☐ Cigar/Pipes # per day_____

Do you drink: ☐ Liquor ☐ Beer ☐ Wine ☐ Coffee number of cups per day:_____

Do you,ever use Recreational Drugs? ☐ Yes ☐ No Do you have trouble sleeping? ☐ Yes ☐ No

Do you routinely use Seat Belts? ☐ Yes ☐ No Do you have fire arms in home? ☐ Yes ☒ No

REVIEW OF SYSTEMS:

Have you had ... within the last 3 months (Check coordinating box of all that apply)	✓	PHYSICIAN'S COMMENTS
fever, night sweats, chills		
unusual weight changes/unusual fatigue		
skin rashes/changes in moles		
trouble with your vision/eye symptoms		
difficulty hearing/ear problems		
nosebleeds		
sinus trouble/hay fever/post nasal drip		
persistent hoarseness		
had difficulty breathing/other lung trouble		
chest pain, tightness, discomfort, or pressure		
swelling of feet or ankles		
pain in calf when walking		

Have you had ... within the last 3 months (Check coordinating box of all that apply)	✓	PHYSICIAN'S COMMENTS
fast or irregular heart beat (palpitations)		
a heart murmur		
had thyroid problems		
been placed in hormone therapy for any condition		
had lumps in your breasts/nipple discharge		
trouble swallowing solids or liquids		
abdominal pain, indigestion or heartburn		
any recent change in bowel movements		
rectal bleeding or tarry/black stools or vomited blood		
gallbladder problems or gallstones		
awake at night to urinate more than 3 times		
prostate enlargement/infections		
blood in your urine/bladder infections/kidney stones		
neck or back pain		
joint pain or stiffness		
any change in the strength of your muscles		
pain or spasm in muscle		
frequent or severe headaches/or migraines		
had excessive snoring or fatigue in the mornings		
have you been depressed		
recently fainted, blacked out or lost consciousness		
have you ever been treated by a psychiatrist		
any treatments for anemia		
had excessive bleeding or bruising		
ever received a blood transfusion		
the menopause/hot flashes/post mensual bleeding		
excessive body or facial hair		

Last pap smear _____

Menstrual History - Last Period (date)_____ Periods: regular irregular light normal heavy

No. of pregnancies_____ No. of miscarriages_____

When was your last mammogram?_____ Do you do breast self exams? yes no

What kind of birth control measures have you used?_____

Are you in a relationship in which you have been physically hurt or threatened by your partner? yes no

Have you ever been in such a relationship? yes no

If you would like to discuss sexual issues with the doctor, please do not hesitate to do so.

_____ _____

Patient Signature Date

_____M.D., D.O. _____

Physician Signature Date

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