Personal Health History

Patient Name ________________________ **Birthdate** ____/____/____

To assist us in meeting all of your healthcare needs, please fill out **both sides** of this form completely in ink.
This is a confidential record of your medical history and will be filed electronically in your chart.

Today's Date ____________________
Place of Birth ____________________
Occupation ____________________
Previous Occupations____________________
Maiden Name (if applicable) ____________________
Hobbies ____________________
Exercise/Recreation ____________________

Habits

Tobacco (Type, Amount/day, Years of use) ____________________
Former Tobacco user, quit date ____________________
Alcohol (Type & Amount/day) ____________________
Caffeine (Type & Amount/day) ____________________
Street drugs (Type & Amount/day) ____________________

Usual weight ____________________
Last Dental Exam Date: ____________________
Please list **all allergies** (Foods/Drugs/Environment) along with reactions:
____
____

When was your last physical exam ____________________
Name of doctor ____________________
Please list all **serious illnesses, surgeries, and other hospitalizations** you have experienced and include the year these occurred.
____
____
____

Current Pharmacy ____________________
Please list **all medicines** (with dose and amount taken per day) you are currently taking, including nonprescription drugs.
____
____
____
____
____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones. Please include date of occurrence.
____

Chief Complaint

Please list in order of importance, the present health concerns, symptoms or problems you are experiencing.
____
____

Past Medical History

Have you ever had the following: (Circle "no" or "yes," please leave blank if uncertain)

Measles	no	yes	Migraine headaches	no	yes	Asthma	no	yes
Mumps	no	yes	Tuberculosis	no	yes	Hives or Eczema	no	yes
Chickenpox	no	yes	Diabetes	no	yes	Aids or HIV+	no	yes
Whooping Cough	no	yes	Type: ________			Infectious Mono	no	yes
Scarlet Fever	no	yes	Cancer	no	yes	Bronchitis	no	yes
Diphtheria	no	yes	Type: ________			Mitral Valve Prolapse	no	yes
Smallpox	no	yes	Polio	no	yes	Stroke	no	yes
Pneumonia	no	yes	Glaucoma	no	yes	Hepatitis	no	yes
Rheumatic Fever	no	yes	Hernia	no	yes	Ulcer	no	yes
Heart Disease	no	yes	Blood or Plasma	no	yes	Kidney Disease	no	yes
Arthritis	no	yes	Transfusions			Thyroid Disease	no	yes
Venereal Disease	no	yes	Back trouble	no	yes	Bleeding tendency	no	yes
Anemia	no	yes	High or Low blood	no	yes	Any other Disease (Please list)		
Bladder Infections	no	yes	Pressure			________		
Epilepsy	no	yes	Hemorrhoids	no	yes	________		

Family History Has any blood relative had any of the following: If yes, specify relative and Mother's/Father's side of family. Example: Uncle, Mother's side

Cancer	no	yes	**What Type** ________	Stroke	no	yes	________
Tuberculosis	no	yes	________	Epilepsy	no	yes	________
Diabetes	no	yes	**What Type** ________	Allergies	no	yes	________
Heart Disease	no	yes	________	Anemia	no	yes	________
High blood pressure	no	yes	________	Bleeding tendency	no	yes	________
Asthma	no	yes	________	Mental Illness	no	yes	________
Lung Disease	no	yes	________	Leukemia	no	yes	________
Drug/Alcohol Prob.	no	yes	________	Migraine headache	no	yes	________
Obesity	no	yes	________	Thyroid Disease	no	yes	________

Family History Has any blood relative had any of the following: If yes, specify relative and Mother's/Father's side of family. Example: Uncle, Mother's side

Ulcer	no	yes	______	Depression	no	yes	______
High Cholesterol	no	yes	______	Kidney Disease	no	yes	______
Glaucoma	no	yes	______	Gout	no	yes	______

	If living, state current age and heath status as good, fair, or poor	If deceased, cause of death and age at the time of death
Father	______	______
Mother	______	______
Siblings	______	______
Spouse	______	______
Children	______	______

Do you have now, or have you had, within the past year: Circle "no" or "yes." If uncertain, leave blank

Weakness or paralysis	no	yes	Sore throat	no	yes	Dark urine	no	yes
Tire easily or weakness	no	yes	Sore tongue or gums	no	yes	Yellow jaundice	no	yes
Recent weight changes	no	yes	Lump or discharge from breast	no	yes	Frequent urination (day)	no	yes
Change in appetite	no	yes	Chronic or frequent cough	no	yes	Frequent urination (night)	no	yes
Sensitivity to cold or heat	no	yes	Shortness of breath	no	yes	Increase in thirst	no	yes
Persistent fever	no	yes	Bloody sputum	no	yes	Painful urination	no	yes
Night sweats or hot flashes	no	yes	Wheezing	no	yes	Leakage of urine	no	yes
Skin rash	no	yes	Chest pain or discomfort	no	yes	Difficulty in starting urine	no	yes
Skin trouble or changes	no	yes	Purple fingers or lips	no	yes	Blood in urine	no	yes
Change in nails or hair	no	yes	Swelling of hands, feet, ankles	no	yes	Lack of sex drive	no	yes
Headaches	no	yes	Difficulty in breathing	no	yes	Hemorrhoids	no	yes
Easy bleeding or bruising	no	yes	Palpitations or fluttering of the Heart	no	yes	Backaches	no	yes
Double vision	no	yes				Joint pain or stiffness	no	yes
Blurred vision	no	yes	Leg cramps on walking or at Night	no	yes	Swollen joints	no	yes
Eye pain	no	yes				Muscle cramps or spasms	no	yes
Last Eye Exam Date: ______			Enlarged veins	no	yes	Sleeplessness	no	yes
Infected eyes	no	yes	Difficulty swallowing	no	yes	Seizures	no	yes
Do you wear glasses/contacts	no	yes	Heartburn	no	yes	Depression	no	yes
Ringing in the ears	no	yes	Frequent belching	no	yes	Memory loss	no	yes
Discharge from ears	no	yes	Abdominal cramping	no	yes	Poor Coordination	no	yes
Ear pain	no	yes	Nausea	no	yes	Dizziness or fainting spells	no	yes
Decrease in hearing	no	yes	Vomiting	no	yes	A living will/advance directive	no	yes
Frequent nosebleeds	no	yes	Vomited or coughed up blood	no	yes	Prior Colonoscopy	no	yes
Frequent colds	no	yes	Chronic diarrhea	no	yes	Date: ______		
Sinus trouble	no	yes	Chronic constipation	no	yes	Bone Density	no	yes
Loss of smell	no	yes	Rectal bleeding	no	yes	Date: ______		
Persistent hoarseness	no	yes	Black tarry stools	no	yes			

Men Only

Discharge from penis	no	yes	Impotence	no	yes	Last Prostate Exam Date: ______
Pain or lump in testicles	no	yes				

Women Only

Age period began ______	Is period flow heavy	no	yes	Last Mammogram Date: ______
How many days do periods last ______	Bleed/spot between periods	no	yes	Type of birth control used ______
How many days between periods ______	Do you have pain or cramps	no	yes	Number of pregnancies ______
Last Period Date: ______	Any itching in vaginal area	no	yes	Number of full term births ______
Last Pelvic Exam Date: ______	Pain with intercourse	no	yes	Number of preterm births ______

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

______ Signature of patient/parent if patient is a minor

______ Print Patient's name & Date of birth

______ Date