PATIENT'S PERSONAL HISTORY FORM

NOTE: This is a confidential record and will be kept in this facility or your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

NAME ______________________ Age ________ Date ____________

Occupation ______________________ Birth Place ____________ Birth Date ____________

Dr. ______________________ Date of last Physical Examination ____________

List all States and Countries in which you have lived ______________________

Chief Complaints: (Please list all symptoms.)

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

Please answer each of the following questions by placing an (✓) in the "yes" box if your answer to the question is yes, or by placing an (✓) in the "no" box if your answer to the question is no. Fill in "who" and "when" information when necessary.

FAMILY HISTORY

Has Any Blood Relative Ever Had:

Condition	NO	YES	WHO
Cancer, Including Leukemia	☐ NO	☐ YES	WHO ________
Tuberculosis	☐ NO	☐ YES	WHO ________
Diabetes	☐ NO	☐ YES	WHO ________
Heart Trouble	☐ NO	☐ YES	WHO ________
Heart Attack	☐ NO	☐ YES	WHO ________
High Blood Pressure	☐ NO	☐ YES	WHO ________
Stroke	☐ NO	☐ YES	WHO ________
Epilepsy	☐ NO	☐ YES	WHO ________
Bleeding Disorder	☐ NO	☐ YES	WHO ________
Asthma	☐ NO	☐ YES	WHO ________
Allergies	☐ NO	☐ YES	WHO ________
Liver Disease	☐ NO	☐ YES	WHO ________
Migraine Headaches	☐ NO	☐ YES	WHO ________
Alcoholism	☐ NO	☐ YES	WHO ________
Emphysema	☐ NO	☐ YES	WHO ________
Stomach or Duodenal Ulcer	☐ NO	☐ YES	WHO ________
Kidney Disease	☐ NO	☐ YES	WHO ________
Glaucoma	☐ NO	☐ YES	WHO ________
Sickle Cell Anemia	☐ NO	☐ YES	WHO ________

Family History (continued)

Condition	NO	YES	WHO
Other Anemia	☐ NO	☐ YES	WHO ________
Mental Illness	☐ NO	☐ YES	WHO ________
Suicide	☐ NO	☐ YES	WHO ________
Birth Defects	☐ NO	☐ YES	WHO ________
Other Serious Disease	☐ NO	☐ YES	WHO ________

PERSONAL HISTORY

Do You Smoke? ☐ NO ☐ YES

If Yes, What ____________

How Much ____________

Do You Drink?

- Beer ☐ NO ☐ YES
- Wine ☐ NO ☐ YES
- Other Alcoholic Beverages ☐ NO ☐ YES

How Much of Each? ____________

Are You on a Special Diet? ☐ NO ☐ YES

What Diet? ____________

	Living	Dead	Age at Death	Cause of Death
Father				
Mother				
Brother or Sister				
Husband or Wife				
Son or Daughter				

SYSTEM REVIEW

Do You Have Any of the Following Complaints:

General

Complaint		
Fever	☐ NO	☐ YES
Chills	☐ NO	☐ YES
Aches or Pains	☐ NO	☐ YES
General Weakness	☐ NO	☐ YES
Memory Loss	☐ NO	☐ YES
Swollen Glands	☐ NO	☐ YES
Easy Bruising	☐ NO	☐ YES

Head

Complaint		
Blurred Vision Not Corrected by Glasses	☐ NO	☐ YES
Double Vision	☐ NO	☐ YES
Light Flashes	☐ NO	☐ YES
Halos Around Lights	☐ NO	☐ YES
Pain in Your Eyes	☐ NO	☐ YES
Ear Pain	☐ NO	☐ YES
Drainage from Ear	☐ NO	☐ YES
Hearing Difficulty or Deafness	☐ NO	☐ YES
Buzzing or Ringing in Ears	☐ NO	☐ YES
Nosebleeds Not Due to Injuries	☐ NO	☐ YES
Sinus Trouble	☐ NO	☐ YES
Difficulty Swallowing	☐ NO	☐ YES
Mouth, Tooth or Tongue Problem	☐ NO	☐ YES
Persistent Hoarseness	☐ NO	☐ YES
Severe Headaches	☐ NO	☐ YES
Other ____________	☐ NO	☐ YES

Skin

Complaint		
Changing Mole	☐ NO	☐ YES
Rash	☐ NO	☐ YES
Yellow Skin	☐ NO	☐ YES
Other Skin Problem ____________	☐ NO	☐ YES

Neck

Complaint		
Swelling	☐ NO	☐ YES
Lumps	☐ NO	☐ YES
Stiffness	☐ NO	☐ YES
Other ____________	☐ NO	☐ YES

Chest, Heart, Lungs

Complaint		
Shortness of Breath	☐ NO	☐ YES
Poor Exercise Tolerance	☐ NO	☐ YES
Fluttering of Heart	☐ NO	☐ YES
Unusual Heartbeat	☐ NO	☐ YES
Chest Pain or Pressure Attacks	☐ NO	☐ YES
Frequent Cough	☐ NO	☐ YES
Coughing Up Blood	☐ NO	☐ YES
Wheezing	☐ NO	☐ YES
Night Sweats	☐ NO	☐ YES
Swollen Ankles	☐ NO	☐ YES
Leg Cramps	☐ NO	☐ YES
Other ____________	☐ NO	☐ YES

Gastrointestinal

Complaint		
Poor Appetite	☐ NO	☐ YES
Indigestion or Heartburn	☐ NO	☐ YES
Difficulty Swallowing	☐ NO	☐ YES
Nausea or Vomiting	☐ NO	☐ YES
Vomiting Blood	☐ NO	☐ YES
Abdominal Pain or Cramps	☐ NO	☐ YES
Abdominal Swelling	☐ NO	☐ YES
Diarrhea	☐ NO	☐ YES
Constipation	☐ NO	☐ YES
Change in Bowel Habits	☐ NO	☐ YES
Pass Blood from Rectum	☐ NO	☐ YES
Black, Tar-like Bowel Movements	☐ NO	☐ YES
Other ____________	☐ NO	☐ YES

Kidney

Complaint		
Blood in Urine	☐ NO	☐ YES
Pain or Burning While Urinating	☐ NO	☐ YES
Difficulty Passing Urine	☐ NO	☐ YES
Difficulty Controlling Urine	☐ NO	☐ YES
Getting Up at Night to Urinate	☐ NO	☐ YES
Other ____________	☐ NO	☐ YES

Genitalia

Women

Complaint		
Breast Lump	☐ NO	☐ YES
Discharge from Nipple	☐ NO	☐ YES
Other Breast Problem	☐ NO	☐ YES
Vaginal Discharge	☐ NO	☐ YES
Vaginal Bleeding or Spotting (not with periods)	☐ NO	☐ YES
Hot Flashes	☐ NO	☐ YES
Pain with Intercourse	☐ NO	☐ YES
Possibly Pregnant	☐ NO	☐ YES
Change in Periods	☐ NO	☐ YES
Pain Not Associated with Periods	☐ NO	☐ YES
Other ____________	☐ NO	☐ YES

Men

Complaint		
Breast Lump	☐ NO	☐ YES
Discharge from Penis	☐ NO	☐ YES
Sore on Penis	☐ NO	☐ YES
Lump in Testicles	☐ NO	☐ YES
Difficulty Having Erections	☐ NO	☐ YES
Other ____________	☐ NO	☐ YES

Neuromuscular

Complaint		
Weakness in Arm or Leg	☐ NO	☐ YES
Difficulty with Balance	☐ NO	☐ YES
Dizzy Spells	☐ NO	☐ YES
Fainting Spells	☐ NO	☐ YES
Speech Difficulty	☐ NO	☐ YES
Other ____________	☐ NO	☐ YES

Bones—Joints

Complaint		
Painful Joints	☐ NO	☐ YES
Swollen Joints	☐ NO	☐ YES
Loss of Muscle Strength	☐ NO	☐ YES
Lump or Swelling in Muscle	☐ NO	☐ YES
Lump on Bone	☐ NO	☐ YES
Back Pain	☐ NO	☐ YES
Other ____________	☐ NO	☐ YES

Endocrine

Complaint		
Thirsty All the Time	☐ NO	☐ YES
Cold Most of the Time	☐ NO	☐ YES
Too Warm Most of the Time	☐ NO	☐ YES
Unusually Tired or Sluggish	☐ NO	☐ YES
Unusually Jumpy or Nervous	☐ NO	☐ YES

Psychologic

Do You Find Your Life:

Complaint		
Generally Unsatisfactory	☐ NO	☐ YES
Too Demanding	☐ NO	☐ YES
Boring	☐ NO	☐ YES
Satisfactory	☐ NO	☐ YES

Do You Worry About:

Complaint		
Money	☐ NO	☐ YES
Job	☐ NO	☐ YES
Marriage	☐ NO	☐ YES
Home Life	☐ NO	☐ YES
Children	☐ NO	☐ YES

Do You:

Complaint		
Cry Easily	☐ NO	☐ YES
Feel Inferior to Others	☐ NO	☐ YES
Feel Shy	☐ NO	☐ YES
Feel Things Often Go Wrong	☐ NO	☐ YES
Often Feel Depressed	☐ NO	☐ YES
Have Irrational Fears	☐ NO	☐ YES
Feel Anxious or Upset	☐ NO	☐ YES

Have You:

Complaint		
Seriously Considered Suicide	☐ NO	☐ YES
Attempted Suicide	☐ NO	☐ YES