PATIENT PERSONAL HISTORY

Patient No.:_____

Failure to give 48 hour cancelation notice will result in a $100 No Show Fee.

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			Cell Phone	
Secondary Insurance Company	Insurance Number			Sex (M) (F)	Marital Status (M) (S) (D) (W)

Emergency Contact: _____ Relationship: _____

Address: _____ Phone Number: _____

Date of Last Examination: _____ Doctor: _____

Family or Referring Physician: _____ Address: _____

Reason for Today's Visit:

_____

Is this Visit Worker's Compensation Related? Y ☐ N ☐

If Yes, who is financially responsible for this visit? _____

PAST MEDICAL HISTORY:

High Blood Pressure Y ☐ N ☐

Diabetes Y ☐ N ☐

High Cholesterol Y ☐ N ☐

Other: _____

Other: _____

Other: _____

Other: _____

PAST SURGICAL HISTORY:

Coronary Bypass Y ☐ N ☐

Heart Valve Surgery Y ☐ N ☐

Pacemaker/Defibrillator Y ☐ N ☐

Stents/Angioplasty Y ☐ N ☐

Other: _____

Other: _____

Other: _____

Other: _____

Please List Allergies Below:

_____

_____

_____

_____

_____

Concerns/Additional Medications:

Family History:

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

Do you know of any blood relative who had or has: ***(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 the bottles (including over the counter drugs) to the visit. Otherwise, please list all of the medications, strength, and number taken below.

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

Please list additional medicines on the back of the page

Vitamins?	Y ☐	N ☐	Please List: _____
Herb (eg. Teas/drinks)?	Y ☐	N ☐	Please List: _____
Oral Contraceptives?	Y ☐	N ☐	Please List: _____

Occupation: _____ Employer: _____

[ ] Retired [ ] Disabled

Tobacco Use:	Y ☐ N ☐	Amount: _____	How Long: _____	Year Stopped: _____	
Alcohol Use:	Y ☐ N ☐	Type: _____	Quantity: _____	Frequency: _____	
Illicit Drug Use:	Y ☐ N ☐	Type: _____	How Long: _____	Frequency: _____	
Coffee Use:	Y ☐ N ☐	Amount: _____	How Long: _____	Frequency: _____	
Tea Use:	Y ☐ N ☐	Amount: _____	How Long: _____	Frequency: _____	
Soft Drink Use:	Y ☐ N ☐	Amount: _____	How Long: _____	Frequency: _____	
Exercise Regularly?	Y ☐ N ☐	What kind: _____		How Often: _____	

Review Of Systems:

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

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Headache
- ☐ Major Weight Change
- ☐ Appetite Loss
- ☐ Snoring
- ☐ Stop Breathing During Sleep
- ☐ Sleep on More Than 1 Pillow

Skin
- ☐ Rash
- ☐ Itch
- ☐ Ulcers on Feet
- ☐ Unexplained Hair Loss

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea/Vomiting
- ☐ Heartburn
- ☐ Mucous in the Stool
- ☐ Blood in Stool

Genitourinary
- ☐ Difficulty Urinating
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Urinate More Than Twice At Night

Ear/Nose/Mouth/Throat
- ☐ Ear Infection
- ☐ Sore Throat
- ☐ Sinus Problems
- ☐ Difficulty Swallowing
- ☐ Hoarseness

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
  - ☐ Controlled
  - ☐ Uncontrolled
- ☐ Varicose Veins
- ☐ Swelling in Ankles/Feet

Respiratory
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of Breath
  - ☐ With exertion
  - ☐ Without exertion
- ☐ Asthma
- ☐ Emphysema

Musculoskeletal
- ☐ Joint Pain
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Leg/Hip Pain When Walking

Hematologic/Lymphatic
- ☐ Swollen Glands
- ☐ Blood Clotting Problems
- ☐ Unexplained Bruising

Eyes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Cataracts
- ☐ Glaucoma

Neurological
- ☐ Tremors
- ☐ Dizziness
- ☐ Numbness
- ☐ Arm/Leg Weakness

Allergic/Immunologic
- ☐ Allergies
- ☐ Hay Fever

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Unusual Stress
- ☐ Eating Disorder
- ☐ Suicide Attempt

Endocrine
- ☐ Thyroid Problems
- ☐ Hot Flashes
- ☐ Cold Intolerance

For MEN Give date of last:

Prostate Exam ___/___/___ PSA ___/___/___

☐ Difficulty with Erections

For WOMEN Give date of last:

Menstruation ___/___/___ Pap Smear ___/___/___

Breast Exam ___/___/___ No. of Pregnancies ____

Date of last: Pneumovax ___/___/___ Flu shot ___/___/___ Tetanus ___/___/___ Colonoscopy ___/___/___

Patient Signature: _____ Date ___/___/___ Physician Signature: _____