PATIENT HISTORY

Name ______ DOB / Age ______ Single / Married ______ Divorced / Widow(er) ______ Date ______

Occupation ______ All previous occupations ______ Religion ______

Birth Place ______ Name of Spouse ______

Education: Years Completed ______ High School. ______ College. ______ Post Grad. ______ Highest Degree Obtained

Do you have a Living Will? Yes ☐ No ☐

Date of last physical examination ______

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

FAMILY HISTORY	If Living		If Deceased	
	Age	Health	Age at death	Cause
Father				
Mother				
Siblings (B / S)				
(B / S)				
(B / S)				
(B / S)				
(B / S)				
Husband or Wife				
Children (S / D)				
(S / D)				
(S / D)				
(S / D)				
(S / D)				
(S / D)				

Has any blood relative ever had :	Please circle No or Yes	Relationship
Heart Attack	no yes	
Diabetes	no yes	
Cancer	no yes	
Stroke	no yes	
Mental Illness	no yes	
Suicide	no yes	
Other	no yes	

PERSONAL HISTORY

MEDICAL:

______

MEDICATIONS:

______

ALLERGIES: No ☐ Yes ☐

You are allergic to . . .

List Drug Allergies

______

List Food Allergies

______

List Any Other Allergies

______

INJURIES: have you had any

Broken or cracked bones ______ no yes

Lacerations (Severe) ______ no yes

Dislocations ______ no yes

Concussion, or head injury ______ no yes

WEIGHT: now______, one year ago ______

Maximum ______, when ______

TRANSFUSIONS: have you ever had

Blood or Plasma transfusion______ no yes

Date ______

SURGERY: Have you had

Tonsillectomy ______ no yes

Appendectomy ______ no yes

Any other operation ______ no yes

Procedure ______ Year ______

Procedure ______ Year ______

Procedure ______ Year ______

Procedure ______ Year ______

Colonoscopy no yes Date ______

Have you ever been advised to have any surgical operation which has not been done ______ no yes

______

Have you been hospitalized for any illness ______ no yes

Give details :

______

Please Turn Page Over

RADIOLOGY STUDIES: Have you ever had x-rays of

CT ______ no yes

MRI ______ no yes

Date of last Dexascan ______

IMMUNIZATIONS: Have you had

Tetanus shots (not antitoxin which lasts only 2 weeks) no yes

Date of most recent Tetanus ______

Flu Vaccine ______ no yes

Pneumonia Vaccine ______ no yes

Hepatitis A ______ no yes

Hepatitis B ______ no yes

Other ______ no yes

SYSTEMS: Do you now have or have you ever had (of significance)

Any eye disease, injury, impaired sight ______ no yes
Any ear disease, injury, impaired hearing ______ no yes
Any trouble with nose, sinuses, mouth, throat ______ no yes
Fainting spells ______ no yes
Loss of consciousness/Concussion ______ no yes
Convulsions ______ no yes
Paralysis ______ no yes
Dizziness ______ no yes
Frequent or severe headaches ______ no yes
Depression or anxiety ______ no yes
Hallucinations ______ no yes
Enlarged glands ______ no yes
Thyroid disease or goiter ______ no yes
Skin Disease ______ no yes
Chronic or frequent cough ______ no yes
Chest pain or angina pectoris ______ no yes
Spitting up blood ______ no yes
Night sweats ______ no yes
Shortness of breath ______ no yes
Heroic Snoring ______ no yes
Apnea while sleeping ______ no yes
Palpitation or fluttering heart ______ no yes
Swelling of hands, feet, or ankles ______ no yes
Varicose veins ______ no yes
Extreme tiredness or weakness ______ no yes
Kidney disease or stones ______ no yes
Difficulty in urinating ______ no yes
Abnormal thirst ______ no yes
Stomach trouble or ulcer ______ no yes
Indigestion ______ no yes
Liver or gall bladder disease ______ no yes
Colitis or other bowel disease ______ no yes
Hemorrhoids or rectal bleeding ______ no yes
Constipation or Diarrhea ______ no yes
Has there been any recent change in -
Your appetite or eating habit ______ no yes
Your bowel action or stools ______ no yes

HABITS:

Exercise adequately? ______ yes no

How? ______

Sleep well? ______ yes no

Do you snore excessively, stop breathing during sleep

or have daytime drowsiness? ______ no yes

Alcoholic beverages: never ☐ rarely ☐ moderate ☐ daily ☐

Have you ever been treated for alcoholism ______ no yes

Tobacco: Cigarettes ______ packs per day currently

Cigars ☐ Pipe ☐ Chewing Tobacco ☐ Snuff ☐

Ever smoked ______ no yes

How many years ______

Illicit Drugs: ______

Sex – entirely satisfactory? ______ yes no

Work ______ hrs. per day – indoors ☐ outdoors ☐

Do you like your work? ______ no yes

Recreation:

Do you participate in sports or have

any hobbies? ______ no yes

______

______

WOMEN ONLY

Menstrual History

Age at onset ______

Regular – yes ☐ no ☐

Cycle – ______ days (from start to start)

Usual duration – ______ days

Heavy ☐ Medium ☐ Light ☐

Pains or cramps – yes ☐ no ☐

date of last period ______

date of last mammogram ______ Last PAP ______

Pregnancies

How many children born alive ______

How many stillbirths ______

How many prematures ______

How many Cesarean Sections ______

How many miscarriages ______

Any complications with any pregnancy ______ no yes

MEN ONLY

Date of last PSA test ______