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 __________