

Patient Name _____
Date _____
Address _____
Home Phone # _____ Work Phone # _____

PERSONAL HISTORY

Birthplace _____ Date of Birth _____ Age _____
Nationality _____ Religion _____
Marital Status _____ Health of spouse _____
Occupations _____

Residence past 5 years _____
Education through _____ grade Sleep (usual hrs.) _____ Aids to sleep _____
Recreation _____

Exercise _____
Average per day:
Alcohol (type) _____
Tea, Coffee _____
Tobacco (type) _____

What is your past smoking history? _____
Do you have a history of illegal drug use? yes _____ no _____
Have you ever been at risk or had exposure to a sexually transmitted disease or HIV? yes _____ no _____
Do you wear seat belts? yes _____ no _____
What is your past occupational lung exposure? _____

Medicines taken regularly	Dose	Frequency	Reason

PERSONAL PAST HISTORY (Circle "yes" or "no". If "yes" give year of occurrence.)

HAVE YOU EVER HAD:

MEASLES	YES	NO
MUMPS	YES	NO
WHOOPING COUGH	YES	NO
POLIO	YES	NO
SCARLET FEVER	YES	NO
DIPHTHERIA	YES	NO
MENINGITIS	YES	NO
INFECTIOUS MONO	YES	NO
VALLEY FEVER	YES	NO
TUBERCULOSIS	YES	NO
EXPOSURE TO TB	YES	NO
MALARIA	YES	NO
VENEREAL DISEASE	YES	NO
ARTHRITIS	YES	NO
BACK TROUBLE	YES	NO
BRONCHITIS	YES	NO
PNEUMONIA	YES	NO
PLEURISY	YES	NO
ASTHMA	YES	NO
EMPHYSEMA	YES	NO
RHEUMATIC FEVER	YES	NO
HIGH BLOOD PRESSURE	YES	NO
HEART DISEASE	YES	NO
STROKE	YES	NO
SEIZURES	YES	NO
MIGRAINE HEADACHES	YES	NO
HIVES	YES	NO
HAY FEVER/SINUSITIS	YES	NO
GLAUCOMA	YES	NO
NOSE BLEEDS	YES	NO
ANEMIA	YES	NO
BLEEDING TENDENCY	YES	NO
BLOOD TRANSFUSION	YES	NO
DIVERTICULOSIS	YES	NO
ALCOHOLISM	YES	NO
PANCREATITIS	YES	NO
HEPATITIS (YELLOW JAUNDICE)	YES	NO
GALL STONE	YES	NO
ULCER	YES	NO
HEMORRHOIDS	YES	NO
BLADDER INFECTIONS	YES	NO
KIDNEY DISEASE	YES	NO
KIDNEY STONE	YES	NO
PELVIC DISEASE	YES	NO
DIABETES	YES	NO
THYROID DISEASE	YES	NO
CANCER	YES	NO

ALLERGIES TO MEDICATIONS LIST: _____

OTHER ALLERGIES: _____

IMMUNIZATIONS: YEAR

TETANUS	YES	NO
POLIO SHOTS	YES	NO
POLIO ORAL	YES	NO
MEASLES	YES	NO
PNEUMONIA	YES	NO
INFLUENZA	YES	NO
HEMOPHILUS	YES	NO
TB TEST POSITIVE?	YES	NO

INJURIES:

HEAD	YES	NO
CHEST	YES	NO
ABDOMEN	YES	NO
BROKEN BONES	YES	NO
BACK / NECK	YES	NO
OTHER	YES	NO

OPERATIONS:

TONSILS	YES	NO
APPENDIX	YES	NO
GALL BLADDER	YES	NO
STOMACH	YES	NO
BREAST	YES	NO
UTERUS AND/OR OVARY	YES	NO
PROSTATE	YES	NO
HERNIA	YES	NO
THYROID	YES	NO
VARICOSE VEINS	YES	NO
HEMORRHOIDS	YES	NO
HEART	YES	NO
OTHER	YES	NO

OTHER SERIOUS ILLNESS: _____

Name: _____

MY DESIRES CONCERNING LIFE SUPPORT ARE AS FOLLOWS:

_____ I would never want resuscitation or life support. _____
_____ I would want resuscitation or life support only if something happened that was easily correctable. _____
_____ I want everything possible done to prolong my life, even if I were in a permanent coma. _____

ADVANCED DIRECTIVE:

_____ I have executed an Advanced Healthcare Directive, Durable Power of Attorney for Healthcare, Living will, or Health Care Proxy: _____
_____ Copy placed in chart (Indicate which one) _____
_____ I would like to fill out an Advanced Healthcare Directive _____
_____ Packet provided to patient by _____
_____ Patient does not wish information at this time. _____

FAMILY HISTORY – Has any blood relative had any of the following:
Circle "yes" or "no"—If so, what relationship:

Anemia	yes	no	_____
Asthma	yes	no	_____
Bleeding tendency	yes	no	_____
Cancer (Type)	yes	no	_____
Chronic lung disease	yes	no	_____
Chronic diarrhea	yes	no	_____
Convulsions or fits	yes	no	_____
Diabetes	yes	no	_____
Gout	yes	no	_____
Heart disease	yes	no	_____
High blood pressure	yes	no	_____
Kidney disease	yes	no	_____
Leukemia	yes	no	_____
Mental illness	yes	no	_____
Migraine headaches	yes	no	_____
Obesity	yes	no	_____
Peptic ulcer	yes	no	_____
Repeated Infections	yes	no	_____
Severe allergies	yes	no	_____
Thyroid trouble	yes	no	_____
Tuberculosis	yes	no	_____

	Present Age	Age at Death	If living, health (good, fair, poor) if deceased, cause of death
Father			
Mother			
Brothers or Sisters			
1.			
2.			
3.			
4.			
5.			
6.			
7.			
Children			
1.			
2.			
3.			
4.			
5.			
6.			
Others who live at your house			
Relationship			Health
1.			
2.			

Doctors Notes _____
History # _____

PATIENT NAME: _____
 HAVE YOU RECENTLY HAD THE FOLLOWING?
 CIRCLE "YES" OR "NO"; IF IN DOUBT, LEAVE BLANK.

SYSTEMS REVIEW

Please complete this side for repeat examinations.

GENERAL

TIRE EASILY, WEAKNESS	YES	NO
MARKED WEIGHT CHANGE	YES	NO
NIGHT SWEATS	YES	NO
PERSISTENT FEVER	YES	NO
SENSITIVITY TO HEAT	YES	NO
SENSITIVITY TO COLD	YES	NO

SKIN

ERUPTIONS (RASH)	YES	NO
CHANGE IN COLOR	YES	NO
CHANGE IN HAIR	YES	NO
CHANGE IN NAILS	YES	NO

EYES

TROUBLE SEEING	YES	NO
EYE PAIN	YES	NO
INFLAMED EYES	YES	NO
DOUBLE VISION	YES	NO
WORN GLASSES	YES	NO

EARS

LOSS OF HEARING	YES	NO
RINGING IN EARS	YES	NO
DISCHARGE	YES	NO

NOSE

LOSS OF SMELL	YES	NO
FREQUENT COLDS	YES	NO
OBSTRUCTION	YES	NO
EXCESS DISCHARGE	YES	NO
NOSEBLEEDS	YES	NO

MOUTH

SORE GUMS	YES	NO
SORENESS OF TONGUE	YES	NO
DENTAL PROBLEMS	YES	NO

THROAT

POSTNASAL DRAINAGE	YES	NO
SORENESS	YES	NO
HOARSENESS	YES	NO

BREASTS

LUMPS	YES	NO
DISCHARGE	YES	NO

CARDIO-RESPIRATORY SYSTEM

COUGH, PERSISTING	YES	NO
SPUTUM (PHLEGM)	YES	NO
BLOODY SPUTUM	YES	NO
WHEEZING	YES	NO
CHEST PAIN OR DISCOMFORT	YES	NO
PAIN ON BREATHING	YES	NO
SHORTNESS OF BREATH	YES	NO
DIFFICULTY BREATHING WHILE LYING DOWN	YES	NO
SWELLING OF ANKLES	YES	NO
BLUISH FINGERS OR LIPS	YES	NO
HIGH BLOOD PRESSURE	YES	NO
PALPITATIONS	YES	NO
VEIN TROUBLE	YES	NO

ENDOCRINE

THYROID TROUBLE	YES	NO
ADRENAL TROUBLE	YES	NO
CORTISONE TREATMENT	YES	NO
DIABETES	YES	NO

GYN-OB

Started menstruating at age _____ . Date of last PAP test _____

Interval between periods _____ days Duration _____ days

Flow: light normal heavy Date of last period _____

Pain with periods: yes no duration _____

Number of pregnancies _____ Number of miscarriages _____ Number of births _____

Weight of babies at birth _____

Contraception _____ Last Mammogram _____

Frequency of Breast Self Examination _____

GASTRO-INTESTINAL

CHANGE IN APPETITE	YES	NO
DIFFICULTY SWALLOWING	YES	NO
HEARTBURN	YES	NO
ABDOMINAL DISTRESS	YES	NO
BELCHING OR EXCESS GAS	YES	NO
ABDOMINAL ENLARGEMENT	YES	NO
NAUSEA	YES	NO
VOMITING	YES	NO
VOMITING OF BLOOD	YES	NO
RECTAL BLEEDING	YES	NO
TARRY STOOLS	YES	NO
DARK URINE	YES	NO
JAUNDICE	YES	NO
CONSTIPATION	YES	NO
DIARRHEA	YES	NO
HEMORRHOIDS	YES	NO
NEEDS FOR LAXATIVES	YES	NO

GENITOURINARY SYSTEM

INCREASE IN FREQUENCY OF URINATION (DAY)	YES	NO
DISCOMFORT WITH URINATION	YES	NO
INCREASE IN FREQUENCY OF URINATION (NIGHT)	YES	NO
FEEL NEED TO URINATE WITHOUT MUCH URINE	YES	NO
UNABLE TO HOLD URINE	YES	NO
BLOOD IN URINE	YES	NO
PROTEIN IN URINE	YES	NO
PELVIC PAIN	YES	NO
DISCHARGE FROM VAGINA	YES	NO
VAGINAL ITCH	YES	NO
IMPOTENCE	YES	NO
LACK OF SEX DRIVE	YES	NO
PAIN WITH INTERCOURSE	YES	NO

LOCOMOTOR

MUSCLE CRAMPS	YES	NO
MUSCLE WEAKNESS	YES	NO
PAIN IN JOINTS	YES	NO
SWOLLEN JOINTS	YES	NO
STIFFNESS	YES	NO
DEFORMITY OF JOINTS	YES	NO
NECK PAIN	YES	NO
BACK PAIN	YES	NO

NERVOUS SYSTEM

HEADACHES	YES	NO
DIZZINESS	YES	NO
FAINING	YES	NO
CONVULSIONS OR FITS	YES	NO
NERVOUSNESS	YES	NO
SLEEPLESSNESS	YES	NO
DEPRESSION	YES	NO
CHANGE IN SENSATION	YES	NO
MEMORY LOSS	YES	NO
POOR COORDINATION	YES	NO
WEAKNESS OR PARALYSIS	YES	NO

Description of medical symptoms at this time

Name _____ Date _____ History No. _____