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Personal History Form

Confidential record: Information contained on this form will not be released except when you have authorized us to do so. Please answer *all* questions truthfully and to the best of your knowledge. This information will be used by the doctor to make decisions about your care.

Date _____

Name _____
Last First Middle

Date of Birth _____ **Ht** _____ **Wt** _____ **Sex**: M F **Marital Status**: S M W D

Personal Physician _____ Address _____

Referring Physician _____ Address _____

MEDICAL HISTORY

List any allergies or reactions to medications, latex, tape, food, etc.: _____

_____

Medical conditions that you have had, or that are currently being treated: _____

_____

_____

Names and years of any operations you have had: _____

_____

_____

List dose/frequency of any medications that you take: _____

_____

List any blood thinners that you take: _____

List any herbal remedies/nutritional supplements you use: _____

Serious injuries or accidents: _____ Date of last tetanus booster: _____

Date/place of last chest x-ray: _____ Date/place of last EKG: _____

Date/place of last blood work: _____

yes no Do you smoke? How many packs per day? _____ For how many years? ____

yes no Do you usually drink greater than 6 cups of coffee per day?

yes no Do you regularly drink alcohol or beer? How much? _____

yes no Do you have a history of street drug use, or abuse of prescription drugs?
If so, list all drugs _____

Reverse side also please

MEDICAL HISTORY (CONTINUED)

Do you currently have, or have you experienced: (circle yes or no- if yes, give date of occurrence)

Stroke	No Yes_____	Heavy skin scarring	No Yes_____
Epilepsy, seizures, or convulsions	No Yes_____	Herpetic skin infections	No Yes_____
Multiple sclerosis	No Yes_____	High blood pressure	No Yes_____
Cerebral palsy	No Yes_____	Low blood pressure	No Yes_____
Parkinson's disease	No Yes	Jaundice	No Yes_____
Depression	No Yes_____	Liver disease	No Yes_____
Heart Attack	No Yes_____	Hepatitis	No Yes_____
Chest pains, angina	No Yes_____	Bladder infection	No Yes_____
Palpitations, fast or irregular heart beat	No Yes_____	Kidney disease	No Yes_____
Heart murmur	No Yes_____	Diabetes	No Yes_____
Congenital heart disease	No Yes_____	Low blood sugar	No Yes_____
Rheumatic fever	No Yes_____	Thyroid problems	No Yes_____
Bronchitis or chronic cough	No Yes_____	Goiter	No Yes_____
Asthma	No Yes_____	Cancer	No Yes_____
Pneumonia	No Yes_____	Leukemia	No Yes_____
Emphysema/COPD	No Yes_____	Bleeding tendency	No Yes_____
Shortness of breath	No Yes_____	Anemia	No Yes_____
Other lung problems	No Yes_____	Sickle cell anemia	No Yes_____
Stomach ulcers	No Yes_____	Arthritis	No Yes_____
Colitis	No Yes_____	Sciatica	No Yes_____
		Glaucoma, eye problems	
		AIDS or HIV +	No Yes_____
		Others:	
		_____	

WOMEN ONLY

Is there any possibility that you might be pregnant? No Yes

Do you currently have, or have you experienced: (circle)

Breast lumps	No	Yes	Blood relatives		
Breast biopsies	No	Yes	with breast cancer	No	Yes
Other breast surgery	No	Yes	relationship _____		
Diagnosis of breast cancer	No	Yes			
Nipple discharge	No	Yes	Date of last mammogram _____		
Painful breasts	No	Yes			
			Date of last menstrual period _____		

FAMILY HISTORY

Do you know any blood relative who has, or had: (circle yes or no- if yes, give relationship)

Stroke	No Yes_____
Cancer	No Yes_____
High blood pressure	No Yes_____
Heart attack or other heart disease	No Yes_____
Congenital heart disease	No Yes_____
High fevers with surgery	No Yes_____
Bleeding tendency	No Yes_____
Diabetes	No Yes_____
Birth defect	No Yes_____
Others:	
_____	