

PATIENT PERSONAL HISTORY

Note to Patient: The Physicians and Nurses request that you complete this brief history form to enable them to provide you with the best care possible. This form will become a part of your medical record which is considered CONFIDENTIAL.

Name _____ DOB _____ SSN _____ Date _____

MEDICATION ALLERGIES

1.	2.	3.	4.	5.
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IMMUNIZATIONS	DATES	HOSPITALIZATIONS - SURGERIES	DATES
FLU			
PNEUMOVAX			
TETANUS/DT/TD			
POLIO		PRIVATE PHYSICIANS (LIST BELOW)	TELEPHONE NUMBERS
HEMOPHILUS TYPE B		1.	
MMR		2.	
HEPATITIS B		SOCIAL HISTORY Do you smoke? <input type="checkbox"/> Y <input type="checkbox"/> N How much? _____ Do you use any other tobacco products? <input type="checkbox"/> Y <input type="checkbox"/> N What? _____ Do you drink alcohol? <input type="checkbox"/> Y <input type="checkbox"/> N How much? _____ Do you take any illegal drugs? <input type="checkbox"/> Y <input type="checkbox"/> N What? _____	
HEPATITIS A			
TB SKIN TEST			

PERSONAL HISTORY

Please circle any of the following conditions you have had:

- | | |
|---|--|
| 1. Allergies
2. Diabetes
3. Seizures or Epilepsy
4. Tuberculosis (TB)
5. Cancer
6. Sexually Transmitted Diseases
7. Ulcer
8. Any Incurable Disease
9. Alcoholism
10. Hepatitis
11. Rheumatic Fever
12. Emphysema
13. Recent 10 lb weight change
14. Asthma
15. High Blood Pressure
16. Stool Black like Tar
17. Moles Changing
18. AIDS or HIV Positive
19. Arrested or DWI (Driving While Intoxicated) | 20. Heart Attack/Heart Disease
21. Swollen Legs
22. Heart Murmur
23. Back Pain
24. Arthritis
25. Stroke
26. Headaches
27. Blood Disorder/Bleeding
28. Shortness of Breath
29. Pneumonia
30. Suicide concidered
31. Nightmares
32. Anemia or Low Blood Count
33. Cry Easily
34. Liver Problems or Jaundice
35. Get up at night to urinate
36. Kidney Trouble or Problems Urinating
37. Breast or Testicular Lump
38. Loss of Appetite
39. Elevated Cholesterol |
|---|--|

Please explain all items circled above:

FAMILY HISTORY

Does any member of your family suffer from any of the conditions above?

MOTHER	Hearing Screening - Every 5 Yrs
FATHER	
BROTHER/SISTER(S)	
CHILD(REN)	
OTHER	

OCCUPATIONAL HISTORY

Exposures (Date)

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FOR CLINIC USE ONLY

HEALTH MAINTENANCE CONSIDERATIONS	DATES
Annual History & Physical	
EKG - 50+, Every 5 Years	
Cholesterol - 20+, Every 5 Yrs	
Chest X-ray-Smoker-Every 5 Yrs	
PAP/Pelvic Exam	
Breast Self Exam - Monthly	
MAMMO - 35 Baseline, 40-50q 2 yrs, 50+ yearly	
Digital Rectal Exam - 40+ Yearly	
Occult Blood - 40+ Yearly	
SIG - 50+ Every 3-5 Years	
Dental Exam - Yearly	
Skin Cancer Screening - 40+ Yrly	
Visual Screening - Every 5 Yrs	
Hearing Screening - Every 5 Yrs	