# PATIENT'S PERSONAL HISTORY

Patient No. ______________________

Date ______________________

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

| Last Name | First | Middle | Birth Date | Birth Place |
|---|---|---|---|---|
| | | | | |

| Address | City | State | Zip | Home Phone | Business Phone |
|---|---|---|---|---|---|
| | | | | | |

| Occupation | Medicare No. | Medicaid No. | Sex | Marital Status | Religion |
|---|---|---|---|---|---|
| Insurance Company | | Insurance No. | M F | | |

Person to Notify ______________________ Relationship ______________________

Address ______________________ Phone Number ______________________

Date of Last Physical Examination ______________________ Doctor ______________________

Family or Referring Physician ______________________ Address ______________________

| FAMILY HISTORY | | If Living | | If Deceased | |
|---|---|---|---|---|---|
| | Sex | Age | Health | Age at Death | Cause |
| Father | | | | | |
| Mother | | | | | |
| Brothers/Sisters* *(Circle Sex)* | | | | | |
| | M F | | | | |
| | M F | | | | |
| | M F | | | | |
| | M F | | | | |
| | M F | | | | |
| Husband/Wife | | | | | |
| Sons/Daughters* *(Circle Sex)* | | | | | |
| | M F | | | | |
| | M F | | | | |
| | M F | | | | |
| | M F | | | | |
| | M F | | | | |

**Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter.*

Do you know of any blood relative who has or had: (Circle and give relationship)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Stroke | ______ | Epilepsy | ______ | Heart Attack | ______ | Nervous breakdown | ______ |
| Cancer | ______ | Suicide | ______ | Stomach ulcers | ______ | Rheumatic heart | ______ |
| High blood Pressure | ______ | Migraine | ______ | Kidney disease | ______ | Insanity | ______ |
| Tuberculosis | ______ | Asthma | ______ | Goiter | ______ | Congenital heart | ______ |
| Diabetes | ______ | Hay fever | ______ | Arthritis | ______ | | |
| Leukemia | ______ | Bleeding tendency | ______ | Colitis | ______ | | |

**PERSONAL HABITS:** (Circle)

Yes No Do you regularly smoke? Cigarettes ☐ Pipe ☐ Cigars ☐ For how many years? ______

Yes No Do you usually drink over 6 cups of coffee per day?

Yes No Do you regularly drink alcohol? 1 oz. per day ☐ 2 oz. per day ☐ 4 oz. per day ☐ over 6 oz. ☐;
BEER: 1 bottle per day ☐ 2 bottles per day ☐ over 4 bottles per day ☐.

Yes No Do you have difficulty in falling asleep?

Yes No Do you awaken early in the morning without apparent cause?

## MEDICATIONS:

Are you presently taking any of the following medications? (Circle)

| | | | | | |
|---|---|---|---|---|---|
| Yes | No | Aspirin, bufferin, anacin | Yes | No | Tranquilizers |
| Yes | No | Blood pressure pills | Yes | No | Weight reducing pills |
| Yes | No | Cortisone | Yes | No | Blood thinning pills |
| Yes | No | Cough medicine | Yes | No | Dilantin |
| Yes | No | Digitalis | Yes | No | Shots |
| Yes | No | Hormones | Yes | No | Water pills |
| Yes | No | Insulin or diabetic pills | Yes | No | Antibiotics |
| Yes | No | Iron or poor blood medications | Yes | No | Barbiturates |
| Yes | No | Laxatives | Yes | No | Birth control pills |
| Yes | No | Sleeping pills | Yes | No | Phenobarbital |
| Yes | No | Thyroid medicine | Yes | No | Other drugs not listed |

Write in the names and year of any operations which you have had:

Name any drugs to which you are allergic:

Write in the names of any diseases you have had which required hospitalization:

Serious Illnesses which you have had: (not requiring hospitalization)

Serious injuries or accidents:

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Serious injuries or accidents:

| | | If you have had a change in bowel habit recently answer the following: (Circle) | When or since when? |
|---|---|---|---|
| Yes | No | Crampy pain in the abdomen? | |
| Yes | No | Alternating diarrhea and constipation? | |
| Yes | No | Pain during or after bowel movement? | |
| Yes | No | Mucous in the stool? | |
| Yes | No | Blood in the stool? | |
| Yes | No | Ribbon-like stools? | |
| Yes | No | Black stools? | |
| Yes | No | Require use of strong laxatives or enemas? | |

Have you had: (Circle)

| | | | |
|---|---|---|---|
| Yes | No | Burning when urinating? | |
| Yes | No | Loss of control of bladder? | |
| Yes | No | Blood in the urine? | |
| Yes | No | Dark colored urine? | |
| Yes | No | Trouble starting to urinate? | |
| Yes | No | Trouble holding the urine? | |
| Yes | No | Getting up frequently at night? | |
| Yes | No | Passed a kidney stone? | |

Have you recently had: (Circle)

| | | | |
|---|---|---|---|
| Yes | No | Pains in calves of legs when walking? | |
| Yes | No | Cramps in legs at night? | |
| Yes | No | Pain in the big toe? | |
| Yes | No | Varicose veins? | |
| Yes | No | Phlebitis or inflamed leg veins? | |
| Yes | No | Swelling in the ankles? | |

To be answered by MEN only: Have you ever had: (Circle)

Yes No Loss of sexual activity? For how long? ____________

Yes No Treatment for genitals (private parts)?

Yes No Discharge from penis?

Yes No Hernia (rupture)?

Yes No Prostate trouble?

Describe briefly your present medical symptoms:

american society of internal medicine

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