PATIENT'S PERSONAL HISTORY FORM

Name: _____ Birth Date: _____ Date: _____

Reason for today's visit:

_____

FAMILY HISTORY (Please check the following)
Has Any Blood Relative Ever Had:

Cancer, Including Leukemia □No □Yes Who_____
What Kind of Cancer: _____
Tuberculosis □No □Yes Who_____
Diabetes □No □Yes Who_____
Heart Trouble □No □Yes Who_____
Heart Attack □No □Yes Who_____
High Blood Pressure □No □Yes Who_____
Stroke □No □Yes Who_____
Epilepsy □No □Yes Who_____
Bleeding Disorder □No □Yes Who_____
Asthma □No □Yes Who_____
Allergies □No □Yes Who_____
Liver Disease □No □Yes Who_____
Migraine Headaches □No □Yes Who_____
Alcoholism □No □Yes Who_____
Emphysema □No □Yes Who_____
Stomach or Duodenal Ulcer □No □Yes Who_____
Kidney Disease □No □Yes Who_____
Glaucoma □No □Yes Who_____

Other Anemia □No □Yes Who_____
Mental Illness □No □Yes Who_____
Suicide □No □Yes Who_____
Birth Defects □No □Yes Who_____
Other Serious Disease □No □Yes Who_____
Thyroid Problems □No □Yes Who_____
High Cholesterol □No □Yes Who_____

PERSONAL HISTORY

Do you Smoke or Chew Tobacco? □No □Yes
If Yes, What_____
How Much: _____
Recreational Drug Use? □No □Yes
Type:_____
Do You Drink? □No □Yes
How much of each?
Caffeine: coffee, tea, colas_____
□No □Yes Beer_____
□No □Yes Wine_____
□No □Yes Other Alcoholic Beverages_____
Are you on a Special Diet? □No □Yes
What Diet?_____

	Living or Dead	Age of Death	Cause of death
Father			
Mother			
Brother			
Sisters			
Husband or Wife			
Son's			
Daughters			

Past /Present Medical Problems:

_____
_____
_____

Allergies: Medicines: _____
Others: (foods, environment, etc) _____

List all Current Medicines:
(Prescription, Over the Counter, Herbs, Supplements, etc)

_____
_____
_____
_____

List All Operations:
(Type and Year)

_____
_____
_____
_____

Preventive:

Date of last Menstrual Period: _____
Cholesterol check (year & cholesterol value _____
Colonoscopy or flex sig _____

Last Td Immunization (year) _____
Exercise per week _____
Date of last Physical _____