Patient Personal History

Today's date: _____

Name: _____ Date of Birth: __/___/___

Reason for office visit: _____

Dates of Interest for possible surgery: _____

Married: ____ Single: ____ Number of Children: ____ Ages: _____

Previous Surgeries, Fractures or Injuries (with dates): _____

_____

Have you ever had? (Please answer yes (Y) or no (N).)

___Diabetes	___Musculo/Skeletal Problems	___Thyroid Problems
___High Blood Pressure	___Chest Pain/Palpitations	___Heart Trouble
___Heart Murmurs	___Mitral Valve Prolapse	___Scarlet Fever
___Asthma	___Shortness of Breath	___Lung Problems
___Seizures/Migraines	___Loss of Consciousness	___Hepatitis
___Yellow Jaundice	___Ulcer/Gastric Reflux	___Vomiting Blood
___Kidney Problems	___Blood in Urine	___Measles
___Chicken Pox/Shingles	___Herpes/Cold Sores	___Blood Clots/Legs
___Free Bleeding	___Anesthesia difficulties	___Other_____

Last Mammogram/Results:

_____

Allergies (Food, Drugs, Tape):_____

Medications/Supplements: _____

_____

Have you received psychological counseling any time in the past 5 years? _____

If yes, please explain: _____

Patient Personal History Continued

Name: _____

Is there a family history of?

___Tuberculosis Who? _____ ___ Stroke Who? _____

___Diabetes Who? _____ ___ Epilepsy Who? _____

___Heart Disease Who? _____ ___ Allergy? Who? _____

___Cancer/Type Who? _____

Mother's Health: __Good __Fair__ Poor__ Deceased/Reason: _____

Father's Health: __Good __Fair __Poor __ Deceased/Reason: _____

Have you ever been exposed to or do you have and infectious disease? ___Yes ___ No
If yes, please explain:_____

Have any major changes occurred in your family in the past year? (i.e. death, divorce, illness) Please explain: _____

Please indicate usage/frequency of the following:
__Alcohol (x per week) __Tobacco (x per day) __ Exercise (x per week)

Special Diets:_____

For Office Use Only: