PATIENT'S PERSONAL HISTORY

Patient No. ____________________

Date ____________________

Confidential Record: Information contained on this form will not be released unless you have authorized us to do so.

Last Name: __________ First Name: __________ Middle: __________

Address: __________ City: __________ State/Zip: __________

In care of (Parent or legal guardian): __________ Spouse's Employer: __________

Sex: __________ Birthdate: __________ Marital Status: __________ Soc. Security No.: __________

Home phone:( ) __________ Work phone: ( ) __________ Cell Phone: ( ) __________

Driver's Lic. No.: __________ Person to notify: __________

Relationship: __________ Address: __________ Phone: ( ) __________

Referred by: __________ Address: __________

Occupation of patient (or parent, if patient is a minor): __________ Email Address: __________

Medicare No.: __________ Medicaid No.: __________

Please list all insurance companies:

1. Insurance company's name: ____________________
   Address: ____________________
   Policy Holder's Name: __________ Policy Holder's Soc. Security No.: __________

2. Insurance company's name: ____________________
   Address: ____________________
   Policy Holder's Name: __________ Policy Holder's Soc. Security No.: __________

Family History

Any changes: Yes ☐ No ☐

If yes ____________________

Social History

Any changes: Yes ☐ No ☐

If yes ____________________

Medical History

Any changes: Yes ☐ No ☐

If yes ____________________

REVIEW OF SYSTEMS:

A. GENERAL

- Do you worry a lot about your health? Yes ☐ No ☐
- Do you usually feel tired or worn out? Yes ☐ No ☐
- Do you feel depressed a lot of the time? Yes ☐ No ☐
- Have you recently noticed that heat or warm, weather bothers you? Yes ☐ No ☐
- Have you recently been drinking more water or fluids? Yes ☐ No ☐
- Has there been any unusual weight gain or loss recently? Yes ☐ No ☐
- Are you cold? Yes ☐ No ☐
- Are you hot?
- Do you have sweats at night? Yes ☐ No ☐
- Do you have chills? Yes ☐ No ☐
- Do you have shaking spells? Yes ☐ No ☐

B. SKIN

Have you noticed:

- any change in the color of your skin? Yes ☐ No ☐
- any skin rashes? Yes ☐ No ☐
- usually dry skin? Yes ☐ No ☐
- any growth on your skin that bothers you? Yes ☐ No ☐
- any sores or wounds that don't heal? Yes ☐ No ☐
- any change in color or size of warts or moles? Yes ☐ No ☐

C. EYES

Do you have:

- any pain in your eyes? Yes ☐ No ☐
- glaucoma? Yes ☐ No ☐
- blurred vision? Yes ☐ No ☐
- halos around lights? Yes ☐ No ☐
- change in vision? Yes ☐ No ☐

D. ENT

Do you have:

- any trouble hearing? Yes ☐ No ☐
- ringing or buzzing in your ears? Yes ☐ No ☐
- earaches or discharge from ears? Yes ☐ No ☐
- a lot of nasal stuffiness? Yes ☐ No ☐
- drainage down the back of your throat? Yes ☐ No ☐
- frequent or severe nosebleeds? Yes ☐ No ☐
- persistent hoarseness? Yes ☐ No ☐
- a lump in your throat? Yes ☐ No ☐
- a sore tongue or mouth? Yes ☐ No ☐
- bleeding gums? Yes ☐ No ☐

E. RESPIRATORY

Do you have:

- frequent chest colds? Yes ☐ No ☐
- a constant bothersome cough? Yes ☐ No ☐
- coughing of blood? Yes ☐ No ☐
- sputum or phlegm between colds? Yes ☐ No ☐
- wheezing or whistling in your chest? Yes ☐ No ☐
- shortness of breath when walking or exercising? Yes ☐ No ☐

F. CARDIOVASCULAR

- Do you have pain, tightness or pressure in the front or back of your chest? Yes ☐ No ☐
- If yes, is it when walking fast, working hard or when excited? Yes ☐ No ☐
- Have you ever been told your electrocardiogram was abnormal? Yes ☐ No ☐
- Do you have swelling in your feet/ankles? Yes ☐ No ☐
- Does your heart ever beat fast or irregularly? Yes ☐ No ☐
- Do you have cramps in the calf muscles when you walk? Yes ☐ No ☐
- Do you ever awaken at night with severe difficulty breathing? Yes ☐ No ☐
- Do your fingers or toes ever get cold, become numb, or get very white or bluish? Yes ☐ No ☐

G. GASTROINTESTINAL

- Have you recently had any change in your eating habits? Yes ☐ No ☐
- Are there any special foods that cause your stomach to be upset or have pain or nausea, etc.? Yes ☐ No ☐
- Do you tend to burp a lot? Yes ☐ No ☐
- Have you ever vomited blood? Yes ☐ No ☐
- Are you bothered with constipation? Yes ☐ No ☐
- Do you have frequent loose stools or diarrhea? Yes ☐ No ☐
- Do you pass a lot of gas? Yes ☐ No ☐
- Do you have a poor appetite? Yes ☐ No ☐
- Have you ever passed blood from your rectum? Yes ☐ No ☐
- Have your ever had black or tarry stools? Yes ☐ No ☐
- Have you noticed any recent changes in your bowel movements? Yes ☐ No ☐
- Do you take laxatives regularly? Yes ☐ No ☐
- Do you have frequent nausea and/or vomiting? Yes ☐ No ☐
- Low Blood Sugars Yes ☐ No ☐

H. GENITOURINARY

Do you have:

- Anything wrong with your genitals? Yes ☐ No ☐
- Burning or pain when you urinate? Yes ☐ No ☐
- To urinate frequently? Yes ☐ No ☐
- Trouble urinating? Yes ☐ No ☐
- To get up at night to urinate? Yes ☐ No ☐
- Trouble losing urine when you cough or sneeze? Yes ☐ No ☐
- A problem dribbling urine? Yes ☐ No ☐
- Have you ever passed blood in your urine? Yes ☐ No ☐
- Do you have sexual problems? Yes ☐ No ☐
- Have you had a operation to prevent pregnancy (vasectomy or sterilization such as tubal ligation)? Yes ☐ No ☐
- Men, do you have prostate gland trouble? Yes ☐ No ☐

I. MUSCULOSKELETAL

Do you have:

- Problems with back pain? Yes ☐ No ☐
- Pain in your legs or feet? Yes ☐ No ☐
- Work or activities that back pain interferes with? Yes ☐ No ☐
- Joint pain or stiffness? Yes ☐ No ☐
- Trouble walking or using your hip or knee joints? Yes ☐ No ☐

J. CENTRAL NERVOUS SYSTEM

- Do you have frequent/severe headaches? Yes ☐ No ☐
- Do you have spells of dizziness, light-headedness or faintness? Yes ☐ No ☐
- Have you ever seen double? Yes ☐ No ☐
- Do you sometimes lose track of what happens around you for a short time? Yes ☐ No ☐
- Do you sometimes lose the ability to speak for a few seconds? Yes ☐ No ☐
- Have you recently fainted, blacked out or lost consciousness? Yes ☐ No ☐
- Do you have trouble remembering recent events? Yes ☐ No ☐
- Have you ever had convulsions or fits? Yes ☐ No ☐
- Do you have numbness or tingling in your head, arms, legs or feet? Yes ☐ No ☐
- Do you consider yourself a nervous person? Yes ☐ No ☐
- Do you cry a lot for no reason? Yes ☐ No ☐
- Do you ever hear voices or see people when no one is around? Yes ☐ No ☐
- Do you have thoughts of suicide? Yes ☐ No ☐
- Do you have spells or muscle weakness? Yes ☐ No ☐
- Do you ever have a feeling that Yes ☐ No ☐
- someone is trying to harm you? Yes ☐ No ☐
- Yes ☐ No ☐

K. WOMEN'S ISSUES ONLY

- Did your menstrual periods start before the age of 10 yrs.? Yes ☐ No ☐
- Did your menstrual periods start after the age of 15 yrs.? Yes ☐ No ☐
- Are your menstrual periods irregular? Yes ☐ No ☐
- Are your menstrual periods less frequent than every four weeks? Yes ☐ No ☐
- Do you use more than 10 pads or have to use super size pads/tampons during periods? Yes ☐ No ☐
- Do you pass clots with your periods? Yes ☐ No ☐
- Do you become bloated or gain weight just before your periods? Yes ☐ No ☐
- Have you passed menopause? Yes ☐ No ☐
- Do you have hot flashes? Yes ☐ No ☐
- Have you had any abortions or miscarriages? Yes ☐ No ☐
- Have you had any lumps in your breasts? Yes ☐ No ☐
- Have you ever had discharge from your nipples? Yes ☐ No ☐
- Have you ever used an intrauterine device (IUD)? Yes ☐ No ☐
- Have you used other birth control measures? Yes ☐ No ☐

When did you go through menopause?

____

What has been your maximum height ________ft. ________in.

PLEASE LIST ALL MEDICINES: