PERSONAL HISTORY QUESTIONNAIRE

This information is confidential and will be incorporated into your medical record.

Date of Appt:_____
Name: _____
Age: _____ ***Sex:*** _____
Referring Physician: _____
Who is your family physician?
_____

This box is for office use only! DO NOT COMPLETE
HT: _____ BP: _____ / _____
WT: _____
BSA: _____

History of Present Illness

1. What is the reason for your visit? _____

_____

2. Who was the first doctor you saw for this illness?_____
3. Describe your first symptoms/complaints? _____

_____

4. When did these symptoms first start? _____
5. Do you have pain associated with your symptoms? _____ If YES:

- Where is the pain located? _____
- Is the pain constant or does it come and go? _____
- How would you describe the pain (using words such as sharp, dull, nagging, aching, shooting)? _____
- Are there things that relieve or worsen the pain? _____

_____

6. Do these symptoms include any of the following? (Circle YES or NO)

Chills?	YES	NO	Lack of Appetite?	YES	NO	Itching?	YES	NO
Fever?	YES	NO	Weight Loss?	YES	NO	Fatigue?	YES	NO
Headache?	YES	NO						

6. Did your referring physician do any X-rays, lab work, biopsies, or surgical procedures? _____ If YES:

What tests were done? _____

_____

Where were these tests done? _____

_____

When were these tests done? _____

_____

7. Are you claustrophobic? In other words, does being in a closed in space bother you? _____ If so, how severe is your claustrophobia? _____

SOCIAL HISTORY

1. What is your occupation? _____

Your employer: _____ Highest level of education? _____

2. Marital Status _____ Name of spouse/significant other: _____

3. May we discuss your diagnosis/treatment with family members? _____ IF NO: Please ask to speak to the Privacy Officer when you come for your appointment to fill out a form to restrict disclosures of your health information.

If so, who?_____

4. What pharmacy do you use? _____ Pharmacy Tel #: _____

5. Do you have a "Living Will"? _____

6. Does anyone have Power of Attorney to make healthcare and other decisions for you? _____ If so, who? _____

HABITS

Tobacco

- ☐ Never used
- ☐ Cigarettes _____ Packs/day ____ Years
- ☐ Cigars _____ Per/day ____ Years
- ☐ Pipe _____ Bowls/day ____ Years
- ☐ Dip/Chew
- ☐ Stopped When _____

Alcohol

- ☐ None ☐ Beer/Wine ☐ Whiskey

How Often?

- ☐ 2-4 times weekly ☐ weekly
- ☐ monthly ☐ Less than monthly
- ☐ once or twice a year

☐ stopped When? _____

YOUR FAMILY HISTORY

	Age If Living	Age at Death		# Living	# Deceased
Mother	_____	_____	Brothers	_____	_____
Father	_____	_____	Sisters	_____	_____
			Children	_____	_____

List any **family members** with any of these problems:

(**** Please answer regarding family members, not yourself. Please list the relationship of that family member to you, i.e. **father, mother, sister, etc**).

Cancer – What kind? _____

_____

Diabetes _____

High Blood Pressure _____

Heart Trouble _____

Stroke _____

Tuberculosis (TB) _____

Mental Problems/Suicide _____

Blood Disorders _____

YOUR PAST MEDICAL HISTORY

1. Do **YOU** have any of the following?

   Cancer – What kind? _____

   Blood Problems? _____

   Stroke _____ High Blood Pressure _____

   Diabetes _____ Mental Problems/Suicide Attempts ____

   Heart Trouble _____ Tuberculosis (TB) _____

2. MEDICATIONS – List any medications/pills you **are presently taking**:

	Drug Name	How Often		Drug Name	How Often
a.	_____	_____	e.	_____	_____
b.	_____	_____	f.	_____	_____
c.	_____	_____	g.	_____	_____
d.	_____	_____	h.	_____	_____

(**** Use the back of the page if necessary ****)

3. Are you allergic to any medication that you know of? _____

   What medication? _____

   What type of reaction? _____

4. Are you allergic to seafood or iodine or X-ray dye? _____

   What type of reaction? _____

5. Surgical Operations (please indicate the year in the space provided):

Abdominal _____ Heart Bypass _____ Back Surgery _____

Gallbladder _____ Bladder _____ Kidney Surgery _____

Breast Biopsy _____ Hemorrhoid _____ Kidney Stones _____

Breast Surgery _____ Hiatal Hernia _____ Stomach _____

Chest/Lung _____ Inguinal Hernia _____ Prostate _____

Hysterectomy _____ Hip Joint _____ Cataract _____

Ovaries _____ Other Surgeries _____

_____

_____

6. Have you ever been hospitalized for any reason other than surgery? _____

For what reason? _____

_____

Where (what hospital) _____

_____

When? _____

What doctor put you in the hospital? _____

REVIEW OF SYSTEMS

Please √ only if **you have experienced** the symptoms or description. Please check in the NOW blank if you are currently experiencing the symptoms and PAST if you are not currently experiencing the symptoms but have in the past.

Hematology:

NOW PAST

____ ____ Bleeding?
____ ____ Bruising?
____ ____ Anemia/low blood count?
____ ____ Low white blood cell count?

NOW PAST

____ ____ Low platelet count?
____ ____ Enlarged lymph nodes/kernals?
____ ____ Blood transfusions?
____ ____ Fever?
____ ____ Chills?

Head and Neck:

NOW PAST

____ ____ Lightheadedness, dizziness, or vertigo (losing your balance)?
____ ____ Headaches?
____ ____ Eye disease or injury?
____ ____ Hearing impaired or deafness?
____ ____ Ringing, buzzing in your ears?
____ ____ Stuffy nose, postnasal drip, or sinus attacks?
____ ____ Persistent or recurrent hoarseness?
____ Do you wear glasses? If so: Sometimes? _____ All the time? _____

NOW PAST

____ ____ Fainting attacks?
____ ____ Blurred vision?
____ ____ Double Vision?
____ ____ Glaucoma?
____ ____ Pain in and around your ears?
____ ____ Nosebleeds?
____ ____ Problems in gums/mouth/teeth?

When was the last time your eyes were checked? _____ months ago ____ years ago ____ never
Do you wear dentures? _____ Do you wear hearing aids? _____

Chest:

NOW PAST

____ ____ Bothered by Wheezing?
____ ____ Persistent or chronic cough?
____ ____ Spitting up sputum/phlegm with cough?
____ ____ Shortness or breath on exercising or walking?

NOW PAST

____ ____ Asthma?
____ ____ Coughing up blood?
____ ____ Difficult uncomfortable breathing?

Have you ever worked with or around asbestos? _____
Have you had any contact with anyone with tuberculosis? ____
When was your last chest X-ray? _____ Where? _____

Heart:

NOW PAST

____ ____ Chest pains?
____ ____ Sleep propped up in bed? If yes, how many pillows? _____
____ ____ Fluid retention with ankle/leg swelling?

NOW PAST

____ ____ Leg cramps at night?
____ ____ Awaken at night with smothering spells?
____ ____ Blood pressure problems?

REVIEW OF SYSTEMS

Heart (cont.):

____ ____ Palpitations, skipping or "racing" of your heart?
____ ____ Pain in the legs regularly when you walk any distance?
____ ____ Fingers become painful, white or blue when they get cold?
Have you ever been told that you have a "heart murmur"? _____
Have you ever been told that you had a "heart attack" or "coronary"?_____
Have you ever been told that you have "heart failure"? ____

Gastrointestinal:

NOW	PAST		NOW	PAST	
____	____	Any changes in your appetite recently?	____	____	Any trouble swallowing?
____	____	Bothered by heartburn, indigestion, gas or bloating?			
____	____	Spells of nausea or vomiting?	____	____	Ever vomited blood?
____	____	Problem with pain/cramps in stomach?			
____	____	Stomach ulcers?	____	____	Ever had a colonoscopy?
____	____	Regular problems with diarrhea?	____	____	Problems with constipation?
____	____	Use laxatives or enemas occasionally?	____	____	Pain with your bowel movement?
____	____	Have you ever had an X-ray of the stomach or colon?			
____	____	Have you ever had yellow jaundice or hepatitis?			
____	____	Ever had black tarry stools or bright red blood in your stools?			
____	____	Any history of hemorrhoids?			
____	____	Any recent unexplained weight loss? How much have you lost? _____			
____	____	Any recent unexplained weight gain? How much have you gained? _____			

Urinary Tract:

NOW	PAST		NOW	PAST	
____	____	Frequent Urination?	____	____	Pain or burning on urination?
____	____	Ever had a kidney stone or colic?	____	____	Difficulty urinating?
____	____	Ever had kidney damage or failure?	____	____	Ever pass blood in your urine?

For Women Only

NOW	PAST		NOW	PAST	
____	____	Breast lumps or tenderness?	____	____	Breast discharge?
____	____	Unusual bleeding from vagina?			

Last Menstrual Period Date: _____
Have you ever been pregnant? _____ Number of Pregnancies? _____
Number of Live Births? _____
Have you ever taken hormones? _____ How long? _____
If you have experienced menopause, when did it occur? _____
Do you see a gynecologist? _____ If so, who? _____
Date of Last Pap Smear? _____ Date of Last Mammogram? _____

REVIEW OF SYSTEMS

For Men Only:

NOW	PAST		NOW	PAST	
____	____	Prostate trouble?	____	_____	Lump on testicles?
____	____	Any history of Prostate cancer?	____	_____	Ever had a PSA blood test?
					If so, When? _____

Endocrine:

NOW	PAST		NOW	PAST	
____	____	Any thyroid disease?	____	____	Diabetes?
____	____	Excessive thirst?	____	____	Any glandular or hormonal problems?

Skin:

NOW	PAST		NOW	PAST	
____	____	Rash or itching?	____	____	Varicose Veins?
____	____	Abnormal change in skin color?	____	____	Do you have heat intolerance?
____	____	Night Sweats?	____	____	Do you have cold intolerance?

Nervous System:

NOW	PAST		NOW	PAST	
____	____	Lack of Energy?	____	____	Seizures?
____	____	Tumor?	____	____	Numbness?
____	____	Memory Trouble?	____	____	Depression?

THIS SPACE FOR OFFICE USE ONLY

Other physicians seen: _____

_____

_____

Records Release Obtained? _____

Unable to obtain complete history because: _____

_____

RN/CMA Notes:

History taken and documented by: _____ , _____

____ I have reviewed the history and concur _____ I have reviewed the history with the patient

Signature: _____