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Internal Medicine and Pediatrics

PATIENT'S PERSONAL HISTORY & HEALTH ASSESSMENT

Name of Person Completing this Form: _____

If Not the Patient, Relationship to Patient: _____ Date: _____

Confidential Record: Information contained here will not be released unless you have authorized us to do so, except as required by law.

GENERAL INFORMATION:

PATIENT'S NAME: _____ SOC.SEC.#: _____ D.O.B: _____ SEX: _____

PATIENT'S STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PHONE: ( ) _____

EMPLOYER: _____ EMPLOYER PHONE: ( ) _____

NEAREST RELATIVE/KIN: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: ( ) _____ WORK:( ) _____

NAME OF EMPLOYER: _____ PHONE: ( ) _____

DATE OF LAST PHYSICAL EXAM: _____ PHYSICIAN: _____

INSURANCE: GROUP: _____ WORKERS COMP: _____ OTHER: _____

PAST HISTORY (Personal) and ALLERGIES:

Have you had any of the following illnesses?

	Yes	No		Yes	No		Yes	No		Yes	No
Anemia	☐	☐	Depression	☐	☐	Hay Fever	☐	☐	Mumps	☐	☐
Alcohol Overuse	☐	☐	Diabetes	☐	☐	Heart Attack	☐	☐	Nervous Breakdown	☐	☐
Allergies (Other			Emphysema	☐	☐	Other Heart Disease	☐	☐	Rheumatic Fever	☐	☐
than Medications)	☐	☐	Frequent Kidney or			Hepatitis	☐	☐	Sexually Trans-		
Arthritis	☐	☐	Bladder Infections	☐	☐	High Blood Pressure	☐	☐	mitted Diseases	☐	☐
Asthma	☐	☐	Frequent Lung			Jaundice	☐	☐	Sickle Cell Anemia	☐	☐
Cancer	☐	☐	Infections	☐	☐	Kidney Disease	☐	☐	Stomach Ulcers	☐	☐
Chicken Pox	☐	☐	Gallbladder Disease	☐	☐	Measles	☐	☐	Thyroid Disease	☐	☐
Colitis	☐	☐	Gout	☐	☐	Migraine Headache	☐	☐	Whooping Cough	☐	☐

DO YOU HAVE LIVING WILL ☐ ☐

PERSONAL HABITS:

1) Have you ever smoked? ☐ Yes ☐ No Have you used chewing tobacco? ☐ Yes ☐ No # of yrs. _____
Are you a regular smoker now? ☐ Yes ☐ No If No, when did you quit? _____
Number of cigarettes per day _____ ☐ Cigars ☐ Pipe How many years have you or did you smoke? _____

2) Check if you regularly drink:
Hard liquor, 1-3 oz. per day ☐ Over 3 oz. per day ☐ Beer - 1 bottle per day ☐ Beer - 2 bottles per day ☐
Beer - 3 or more bottles per day ☐ Wine - 1 glass per day ☐ Wine - 2 glasses per day ☐ Wine - 3 or more glasses per day ☐

3) Have you ever used any of the following? Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Speed ☐ Other _____

OPERATIONS: List and indicate approximate year.

_____
_____
_____

SERIOUS INJURIES: (Other than the above)
List injuries and give approximate dates.

_____
_____
_____

HOSPITALIZATIONS: (Other than operations)
List reasons and approximate dates.

_____
_____
_____

DIAGNOSTIC X-RAYS: List and give approximate dates.

_____
_____
_____

RADIATION TREATMENTS: _____

IMMUNIZATIONS: Please give date. Hepatitis B _____ Flu _____ Polio _____
Typhoid _____ Smallpox _____ Tetanus _____ Pneumococcal _____

FAMILY HISTORY	Circle Sex	IF LIVING		IF DECEASED	
		AGE	HEALTH	AGE AT DEATH	CAUSE
Father					
Mother					
Brothers/Sisters	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters	M F				
	M F				
	M F				
	M F				
	M F				

Check if any blood relative has or had any of the following and enter relationship:

	Yes	No	Relative		Yes	No	Relative		Yes	No	Relative
Arthritis	☐	☐		Epilepsy	☐	☐		Migraine	☐	☐	
Asthma	☐	☐		Goiter	☐	☐		Nervous Breakdown	☐	☐	
Bleeding Tendency	☐	☐		Gout	☐	☐		Rheumatic Fever	☐	☐	
Cancer	☐	☐		Hay Fever	☐	☐		Sickle Cell Anemia	☐	☐	
Colitis	☐	☐		Heart Attack	☐	☐		Stomach Ulcers	☐	☐	
Congenital Heart				High Blood Pressure	☐	☐		Stroke	☐	☐	
Disease	☐	☐		Intestinal Polyps	☐	☐		Suicide	☐	☐	
Diabetes	☐	☐		Kidney Disease	☐	☐		Tuberculosis	☐	☐	
Emphysema	☐	☐		Leukemia	☐	☐		Other	☐	☐	

MEDICATIONS:

- ☐ Asthma wheezing medicine
- ☐ Aspirin, Bufferin, Anacin, Tylenol or similar products
- ☐ Blood Pressure Pills
- ☐ Cortisone, Prednisone
- ☐ Cough Medicine
- ☐ Digitalis or heart medicine
- ☐ Hormones
- ☐ Insulin or diabetic pills
- ☐ Anemia medications
- ☐ Laxatives
- ☐ Sleeping Pills/tranquilizers
- ☐ Thyroid medicine
- ☐ Stomach/digestive medicine
- ☐ Weight-reducing pills
- ☐ Blood thinners or Coumadin
- ☐ Dilantin
- ☐ Water pills, diuretics
- ☐ Antibiotics
- ☐ Phenobarbital/barbituates
- ☐ Vitamins
- ☐ Other prescription or over-the-counter drugs

List each drug, its amount, and how often you take it.

Are you allergic to any medications? Yes ☐ No ☐

If yes, please list medications and the reaction you had to them:

PLEASE BRING ALL MEDICINES YOU ARE TAKING TO EVERY VISIT!

OTHER PATIENT COMMENTS:

DO NOT WRITE BELOW THIS LINE:

PHYSICIAN COMMENTS:

PHYSICIAN SIGNATURE

OLD RECORDS REQUESTED: ☐ NO ☐ YES

DOCTOR NAME:

ST. ADDRESS

CITY,ST., ZIP

HOSPITAL NAME:

ST. ADDRESS

CITY, ST., ZIP