PATIENT'S PERSONAL HISTORY FORM

THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN THIS OFFICE. THE INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.

NAME: ______________________________________ AGE: ________ TODAY'S DATE: _______________

REASON FOR TODAY'S VISIT: ____

SYMPTOMS: ____

WAS THIS AN INJURY? YES / NO DATE OF INJURY: ___________________

DATE OF LAST PHYSICAL EXAM: _______________________________

PAST MEDICAL HISTORY: Do you have, or have you ever had, any of the following illnesses? :

Cancer	Yes / No	=>	Type of cancer / Medications used ________________________
Diabetes	Yes / No	=>	Type of diabetes / Medications used ________________________
Heart Problems	Yes / No	=>	Type of heart problems / Medications used _________________
Stroke	Yes / No		
Polio	Yes / No		
Lung Disease	Yes / No	=>	Type of disease / Medications used ________________________
Ulcers	Yes / No		
Gallbladder Disease	Yes / No		
Jaundice	Yes / No		
Kidney Disease	Yes / No		
Bone or Joint Disease	Yes / No		
High Blood Pressure	Yes / No	=>	Medications used ______________________________________
Thyroid Problems	Yes / No	=>	Medications used ______________________________________
Hay fever and/or asthma	Yes / No	=>	Medications used ______________________________________

List all Hospitalizations (What type, When, Where) ____

List all Operations (What type, When, Where) ____

ALLERGIES: (Please circle) Penicillin, Sulfa, Aspirin, Codeine, Demerol, Morphine, Merthiolate, Mercurochrome, Other (please state) ____
Adhesive tape, Latex, any foods (please state) _______________________________________
Do you use, or have you had, Cortisone? Yes / No
Have you ever been treated for alcoholism? Yes / No

Pharmacy preference: ____

List all prescription medications currently taking including dosage and frequency: _______________________
____

List all natural supplements currently taking:____

REVIEW OF SYSTEMS: Do you have, or have you had, problems with any of the following?

HEAD AND NECK:

Frequent headaches	Yes / No
Dizziness	Yes / No
Visual Impairment	Yes / No
Double Vision	Yes / No
Hearing Impairment	Yes / No
Draining Ears	Yes / No
Sinus Trouble	Yes / No
Teeth	Yes / No
Tongue	Yes / No
Throat	Yes / No

G.I.:

Blood in stools or tarry stools	Yes / No
Vomiting Blood	Yes / No
Stomach Pains	Yes / No
Frequent Indigestion	Yes / No
Constipation	Yes / No
Diarrhea	Yes / No

G.U.:

Blood in urine	Yes / No
Frequency of urination	Yes / No
Pain on urination	Yes / No
Kidney stones	Yes / No
Frequent kidney infections	Yes / No

CNS:

Neuritis	Yes / No
Loss of balance	Yes / No
Fainting spells	Yes / No
Convulsions	Yes / No
Paralysis	Yes / No
Frequent kidney infections	Yes / No

CARDIO-RESPIRATORY:

Chronic or frequent colds	Yes / No
Chest pains	Yes / No
Cough up blood	Yes / No
Night sweats	Yes / No
Shortness of breath	Yes / No
Fluttering of the heart	Yes / No
Swelling of the feet or ankles	Yes / No

MUSCULOSKELETAL:

Weakness of arms or legs	Yes / No
Deformity of back, arms or legs	Yes / No
Arthritis	Yes / No
Bone or joint disease	Yes / No
Muscle disease	Yes / No
Any broken bones	Yes / No

What and when ________________________________