Patient History

Name _____ **Date** _____

Address _____

_____

Home Phone # _____

Do you have a Living Will? Yes_____ No _____

Family History *Has any blood relative had any of the following: Circle Yes or No- if so, what relationship:*

Bleeding Tendency	yes	no	_____
Leukemia	yes	no	_____
Crippling Arthritis	yes	no	_____
Heart Disease	yes	no	_____
High Blood Press	yes	no	_____
Kidney Disease	yes	no	_____
Asthma	yes	no	_____
Severe Allergies	yes	no	_____
Diabetes	yes	no	_____
Gout	yes	no	_____
Thyroid Trouble	yes	no	_____
Cancer	yes	no	_____

Personal History

Birth Place_____ Date_____

Marital Status _____ Health of spouse _____

Habits: Sleep _____ hrs/per night

Exercise_____

Average per day:

Alcohol (type) _____

Tobacco (type) _____

Tea, coffee (type) _____

Medicine taken regularly _____

_____

_____

_____

_____

_____

Past History

Have you ever had:		
Tuberculosis	yes	no
Pneumonia	yes	no
Hepatitis(yellow	yes	no
Kidney Disease	yes	no
Hives	yes	no
Asthma	yes	no
Arthritis	yes	no
High Blood Press.	yes	no
Heart Disease	yes	no
Anemia	yes	no
Ulcer	yes	no
Cancer	yes	no
Blood Transfusion	yes	no
Immunizations:		
Tetanus	yes	no
Operations:		
Tonsils	yes	no
Appendix	yes	no
Gall Bladder	yes	no
Breast	yes	no
Uterus &/or Ovary	yes	no
Prostate	yes	no
Hernia	yes	no
Thyroid	yes	no
Heart	yes	no
Other	yes	no
Allergies(are you allergic to):		
Tetanus Antitoxin	yes	no
Penicillin	yes	no
Sulfa	yes	no
Other Drugs	yes	no
List		
_____		
Foods	yes	no
Cosmetics	yes	no
Other	yes	no

Yr. **Are you having any of the following now?**

General		
Marked weight change	yes	no
Night sweats	yes	no
Persistent fever	yes	no
Skin		
New skin growths	yes	no
Rash	yes	no
Eyes		
Trouble seeing	yes	no
Eye pain	yes	no
Double vision	yes	no
Ears		
Loss of hearing	yes	no
Discharge	yes	no
Nose		
Loss of smell	yes	no
Excess discharge	yes	no
Mouth		
Sore gums	yes	no
Soreness of tongue	yes	no
Dental Problems	yes	no
Throat		
Soreness	yes	no
Hoarseness	yes	no
Cardio-Resp. Sys.		
Cough, persisting	yes	no
Sputum(phlegm)	yes	no
Wheezing	yes	no
Chest pain or discomfort	yes	no
Shortness of breath	yes	no
Difficulty breathing while lying down	yes	no
Swelling of ankles	yes	no
High blood pressure	yes	no

Breasts		
Lumps	yes	no
Discharge	yes	no
Digestive System		
Heartburn	yes	no
Nausea	yes	no
Vomiting	yes	no
Vomiting of blood	yes	no
Constipation	yes	no
Diarrhea	yes	no
Genitourinary System		
Increase in frequenc of urination	yes	no
Pain or burning	yes	no
Blood in urine	yes	no
Nervous System		
Dizziness	yes	no
Fainting	yes	no
Depression	yes	no
Memory loss	yes	no
Poor coordination	yes	no
GYN-OB		

Date of last PAP test _____

Interval between periods _____days

Date of last period _____

Duration _____days

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