

# PATIENT'S PERSONAL HISTORY

Date \_\_\_\_\_ Patient Number \_\_\_\_\_

**Confidential Record:** Information contained here will not be released except when you have authorized us to do so.

Last Name	First	Middle	Birth Date	Birth Place
Address		City/State/ZIP	Home Phone	Business Phone
Occupation				
Person to Notify for Emergency		Relationship to Patient		
Address			Phone Number	
City, State, Zip				

Family History	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE AT DEATH	CAUSE
<b>Father</b>				
<b>Mother</b>				
<b>Brothers/Sisters</b> (Please circle sex since some names may be used for either man or women)				
	M F			
	M F			
	M F			
	M F			
	M F			
<b>Sons/Daughters</b> (Please circle sex since some names may be used for either man or women)				
	M F			
	M F			
	M F			
	M F			
	M F			

**Do you know of any blood relative who has or had:** (Circle and give relationship)

Colon polyps _____	Ulcerative colitis _____	Heart attack _____
Colon cancer _____	Peptic Ulcer _____	Kidney disease _____
Other cancer _____	Celiac disease _____	Goiter _____
Gallbladder Disease _____	Diabetes _____	Congenital Heart _____
Pancreatitis _____	Migraines _____	Rheumatic Heart _____
Liver disease _____	High blood pressure _____	Asthma _____
Crohn's disease _____	Bleeding tendency _____	
Other: _____		

**Personal Habits:** (Circle yes or no)

YES NO Do you smoke regularly? Cigarettes \_\_\_\_, Pipe \_\_\_\_, Cigars \_\_\_\_, How many years? \_\_\_\_, How many daily? \_\_\_\_,  
 YES NO Did you smoke? How many? \_\_\_\_, How long? \_\_\_\_, When stopped? \_\_\_\_,  
 YES NO Do you drink over 3 cups of coffee per day?

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YES NO Do you drink alcohol regularly? How much per day/week? (specify) \_\_\_\_\_. For how long? \_\_\_\_\_.  
YES NO Did you drink alcohol in the past? How much per day/week? (specify) \_\_\_\_\_. For how long? \_\_\_\_\_.  
When stopped? \_\_\_\_\_.

**MEDICATIONS:**

Please list all your medications by name, dose, frequency taken and when started.

	NAME	DOSE	FREQUENCY	STARTED
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	Other: Aspirin/pain medication: _____			
8.	Over the counter/herbal medications: _____			

Name any drugs to which you are allergic:

	NAME	REACTION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Write in the names and years of any operations which you have had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Write in the names and dates of any illnesses you have had which required hospitalization:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have the following: (Circle and briefly describe)

Hypertension _____	Bleeding Problems _____
Diabetes _____	Sedation Problems _____
Lung Problems _____	Sleep Apnea _____
Liver Problems _____	Anesthesia Problems _____
Kidney Problems _____	Heart Attack _____
Cancer _____	
Blood or blood product transfusion prior to 1992? _____	
Other: _____	

Serious injuries or accidents:

\_\_\_\_\_  
\_\_\_\_\_

Do you have a history of mitral valve prolapse, other heart valve problems, artificial heart valve, history of endocarditis (heart infection), artificial joints or shunts?

\_\_\_\_\_

Are you required to take antibiotics prior to any dental or medical procedure? Why?

To be answered by **WOMEN** only: (Circle yes or no)

- YES NO Any possibility or probability of pregnancy? Weeks \_\_\_\_\_
- YES NO Are you still having regular monthly menstrual periods? \_\_\_\_\_
- YES NO Do you have a vaginal discharge? \_\_\_\_\_
- YES NO Have you ever had bleeding between your periods? When? \_\_\_\_\_
- YES NO Do you have very heavy bleeding with your periods? When? \_\_\_\_\_
- YES NO Do you feel bloated and irritable before your period? \_\_\_\_\_
- YES NO Are you now on or have you ever taken the birth control pill? When? \_\_\_\_\_
- YES NO Have you ever had a miscarriage? When? \_\_\_\_\_
- YES NO Have you ever had a discharge from the nipple of your breast? When? \_\_\_\_\_
- YES NO Do you regularly have the cancer test of the cervix? Date of your last test: \_\_\_\_\_
- How many children born alive \_\_\_\_\_ How many miscarriages \_\_\_\_\_
- How many stillbirths \_\_\_\_\_ How many cesarean operations \_\_\_\_\_
- How many premature births \_\_\_\_\_ Any complications of pregnancy \_\_\_\_\_
- Date of last menstrual period \_\_\_\_\_

To be answered by **MEN and WOMEN**: (Circle yes or no)

- YES NO Do you frequently have severe headaches or migraines? (If yes, answer the following):
- YES NO Do they cause visual trouble?
- YES NO Do they occur on one side of the head?
- YES NO Do they awaken you at night from sleep?
- YES NO Do they feel like a tight hat band?
- YES NO Do they hurt most in the back of the head and neck?
- YES NO Does aspirin or acetaminophen relieve them?
- 
- YES NO Spells of dizziness? YES NO Have you ever had ear problems?
- YES NO Spells of weakness of an arm or leg? YES NO Frequent nosebleeds?
- YES NO Ringing in ears? YES NO Do you frequently have bleeding gums?
- YES NO Have you ever had convulsions/seizures? YES NO Do you frequently have hoarseness?
- 
- YES NO Have you ever had shortness of breath? (If yes, answer the following):
- YES NO Doing your usual work? YES NO Which causes you to cough?
- YES NO Climbing a flight of stairs? YES NO Accompanied by wheezing?
- YES NO Which awakens you at night? YES NO Have you ever coughed blood?
- YES NO Do you have a chronic cough? YES NO Do you cough up much sputum?
- 
- YES NO Have you ever had pain or tightness in the chest? (If yes, answer the following) which begins when...
- YES NO When exerting yourself? YES NO Radiates down the arm?
- YES NO When walking against a wind? YES NO Disappears if you rest?
- YES NO When walking up a hill? YES NO Occurs only at rest?
- YES NO After a heavy meal? YES NO When walking fast?
- YES NO When upset or excited? YES NO When walking in cold weather?
- YES NO Palpitations YES NO Do you sleep on more than one pillow?

If you have chest pain or tightness, please explain \_\_\_\_\_

YES NO Have you had angina, heart failure or heartbeat irregularity? \_\_\_\_\_

YES NO Have you recently had pain in the stomach? *(If yes, answer the following) which...*

YES	NO	Occurs 1-2 hours after a meal?	YES	NO	Is relieved with milk or eating?
YES	NO	Is brought on by eating fried or gassy foods?	YES	NO	Occurs while eating or immediately after?
YES	NO	Awakens you at night?	YES	NO	Occurs only at rest?
YES	NO	Is relieved by antacid medications?	YES	NO	When walking fast?
YES	NO	Do you frequently have trouble swallowing?	YES	NO	Do you frequently have nausea and vomiting?

**If you have had a change in bowel habit recently, answer the following: (Circle yes or no)**

WHEN OR SINCE WHEN?

YES NO Crampy pain in the abdomen? \_\_\_\_\_

YES NO Alternating diarrhea and constipation? \_\_\_\_\_

YES NO Pain during or after bowel movement? \_\_\_\_\_

YES NO Mucous in the stool? \_\_\_\_\_

YES NO Blood in the stool? \_\_\_\_\_

YES NO Ribbon-like stools? \_\_\_\_\_

YES NO Black stools? \_\_\_\_\_

YES NO Require use of strong laxatives or enemas? \_\_\_\_\_

YES NO Hernia (rupture)? \_\_\_\_\_

**Have you had: (Circle yes or no)**

WHEN OR SINCE WHEN?

YES NO Peptic ulcer disease? \_\_\_\_\_

YES NO Gallbladder disease? \_\_\_\_\_

YES NO Hiatal hernia? \_\_\_\_\_

YES NO Pancreas problems? \_\_\_\_\_

YES NO Crohn's disease? \_\_\_\_\_

YES NO Ulcerative colitis? \_\_\_\_\_

YES NO Lactose intolerance? \_\_\_\_\_

YES NO Polyps? Of what? \_\_\_\_\_

YES NO Cancer? \_\_\_\_\_

YES NO GI surgery? \_\_\_\_\_

YES NO Hernia? \_\_\_\_\_

YES NO GI x-rays, endoscopy, CT scan or ultrasound study? \_\_\_\_\_

If so, where? \_\_\_\_\_

**Have you had: (Circle yes or no)**

WHEN OR SINCE WHEN?

YES NO Burning when urinating? \_\_\_\_\_

YES NO Loss of bladder control? \_\_\_\_\_

YES NO Blood, pus, or air in urine? \_\_\_\_\_

YES NO Dark colored urine? \_\_\_\_\_

YES NO Trouble starting or stopping urine? \_\_\_\_\_

YES NO Getting up frequently at night to urinate? \_\_\_\_\_

YES NO Passed a kidney stone? \_\_\_\_\_

**Have you recently had: (Circle yes or no)**

WHEN OR SINCE WHEN?

YES NO Circulation problems? \_\_\_\_\_

YES NO Arthritis? \_\_\_\_\_

YES NO Gout? \_\_\_\_\_

YES NO Varicose veins? \_\_\_\_\_

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YES NO Phlebitis or inflamed leg veins? \_\_\_\_\_  
YES NO Swelling in the ankles? \_\_\_\_\_

**To be answered by MEN only:**

**Have you ever had:** *(Circle yes or no)*

YES NO Loss of sexual activity? For how long? \_\_\_\_\_

YES NO Hernia (rupture)? \_\_\_\_\_

YES NO Prostate trouble? \_\_\_\_\_

**Describe briefly your present medical symptoms:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_