



## PATIENT INFORMATION

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SEX \_\_\_\_\_

MARITAL STATUS (Circle One)   S   M   W   D   Sep.

PHONE NUMBER \_\_\_\_\_ EDUCATION \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

MILITARY SERVICE (Branch and Years) \_\_\_\_\_

WHERE HAVE YOU RECEIVED YOUR MEDICAL CARE IN THE PAST TWO YEARS?  
 \_\_\_\_\_

ALLERGIES TO MEDICINES OR FOODS? \_\_\_\_\_

**HOSPITALIZATIONS:**

| YEARS | PROBLEM | HOSPITAL | DOCTOR |
|-------|---------|----------|--------|
|       |         |          |        |
|       |         |          |        |
|       |         |          |        |
|       |         |          |        |
|       |         |          |        |

LIST ANY MEDICATIONS YOU HAVE BEEN TAKING IN THE PAST YEAR:  
 \_\_\_\_\_

WHEN WAS YOUR LAST TETANUS SHOT? \_\_\_\_\_

**FAMILY HISTORY**

FOR YOUR FAMILY MEMBERS BELOW, FOLLOW THE LINE ACROSS THE SHEET AND MARK AN "X" IN THE BOXES WHICH INDICATE THEIR PRESENT STATE OF HEALTH, OR THE CAUSE OF THEIR DEATH, AND ANY OF THE ILLNESSES WHICH THEY HAVE EVER HAD. ALSO, PRINT THE NAMES AND AGES OF YOUR RELATIVES IN THE SPACE PROVIDED.

|                                 | LIVING | Age at Death | Diabetes | Cancer (type) | Asthma or Respiratory Problems | High Blood Pressure | Arthritis | Heart Trouble | Bleeding Tendency | Convulsions | Mental Disorder or Nervous Breakdown | Headaches |  |  |
|---------------------------------|--------|--------------|----------|---------------|--------------------------------|---------------------|-----------|---------------|-------------------|-------------|--------------------------------------|-----------|--|--|
| <b>IF LIVING, GIVE AGES</b>     |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
| Maternal Grandmother            |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
| Maternal Grandfather            |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
| Paternal Grandmother            |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
| Paternal Grandfather            |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
| Father                          |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
| Mother                          |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
| Brothers & Sisters Names & Ages |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
|                                 |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
|                                 |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
|                                 |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
|                                 |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
|                                 |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
| Your Marriages and Years Each:  |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
| Children, Names and Ages        |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
|                                 |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
|                                 |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |
|                                 |        |              |          |               |                                |                     |           |               |                   |             |                                      |           |  |  |

**I HAVE HAD:**

| YES | NO |                                  | YES | NO |                                      | YES | NO |                                 |
|-----|----|----------------------------------|-----|----|--------------------------------------|-----|----|---------------------------------|
|     |    | <b>EYE</b>                       |     |    | <b>DIGESTIVE</b>                     |     |    | <b>NEUROLOGICAL</b>             |
|     |    | glasses/contacts                 |     |    | change in weight                     |     |    | seizure/epilepsy                |
|     |    | blurred vision                   |     |    | change in appetite                   |     |    | headaches                       |
|     |    | glaucoma                         |     |    | difficulty in swallowing             |     |    | a) frequency                    |
|     |    | other eye problem                |     |    | frequent indigestion/heartburn       |     |    | b) when was first               |
|     |    |                                  |     |    | ulcer                                |     |    | c) time lasted                  |
|     |    | <b>EAR</b>                       |     |    | vomit blood                          |     |    | d) what part of head            |
|     |    | hearing problem                  |     |    | gallstones/gallbladder disease       |     |    | e) things that help             |
|     |    | ringing                          |     |    | hepatitis/cirrhosis or liver disease |     |    | f) things which worsen          |
|     |    | other problem                    |     |    | recent change in bowel habits        |     |    | g) bothered by light            |
|     |    |                                  |     |    | hemorrhoids                          |     |    | h) bothered by noise            |
|     |    | <b>MOUTH/NOSE</b>                |     |    | hernia                               |     |    | stroke                          |
|     |    | wear dentures                    |     |    | black stools                         |     |    | frequent fainting or dizziness  |
|     |    | hoarseness                       |     |    | rectal bleeding                      |     |    | depression                      |
|     |    | hayfever                         |     |    | diarrhea/constipation                |     |    | considered suicidal             |
|     |    | sinus problems                   |     |    | other stomach or bowel problem       |     |    | nervous tension                 |
|     |    |                                  |     |    |                                      |     |    | want psychiatric help           |
|     |    | <b>RESPIRATORY</b>               |     |    | <b>URINARY</b>                       |     |    |                                 |
|     |    | pneumonia                        |     |    | kidney or bladder disease            |     |    | <b>FEMALE</b>                   |
|     |    | frequent cough                   |     |    | kidney/urine/bladder infection       |     |    | last Pap Smear (date:_____)     |
|     |    | cough blood                      |     |    | kidney stone                         |     |    | total pregnancies (#_____)      |
|     |    | short of breath                  |     |    | bloody/brown urine                   |     |    | miscarriages/abortions (#_____) |
|     |    | asthma/emphysema                 |     |    | get up at night to urinate           |     |    | present birth control           |
|     |    | other lung problem               |     |    | problem starting or stopping urine   |     |    | breast problems                 |
|     |    | last chest x-ray (DATE:_____)    |     |    | prostate problem                     |     |    | regular peroids                 |
|     |    | last TB skin test (DATE:_____)   |     |    | sexual problem                       |     |    |                                 |
|     |    |                                  |     |    | syphilis/gonorrhea                   |     |    |                                 |
|     |    | <b>CARDIOVASCULAR</b>            |     |    |                                      |     |    |                                 |
|     |    | rheumatic fever                  |     |    | <b>HABITS</b>                        |     |    |                                 |
|     |    | heart attack                     |     |    | smoke (brand_____packs/day_____)     |     |    |                                 |
|     |    | high blood pressure              |     |    | drink alcohol (amount and type_____) |     |    |                                 |
|     |    | enlarged heart                   |     |    | wear seatbelts                       |     |    |                                 |
|     |    | heart murmur                     |     |    |                                      |     |    |                                 |
|     |    | abnormal heartbeat               |     |    | <b>ENDOCRINOLOGY</b>                 |     |    |                                 |
|     |    | heart failure                    |     |    | Diabetes                             |     |    |                                 |
|     |    | other heart problem              |     |    | Thyroid                              |     |    |                                 |
|     |    | last EKG(cardiogram)(DATE:_____) |     |    | Impotence                            |     |    |                                 |
|     |    |                                  |     |    |                                      |     |    |                                 |
|     |    | <b>MUSCULOSKELETAL</b>           |     |    |                                      |     |    |                                 |
|     |    | arthritis                        |     |    |                                      |     |    |                                 |
|     |    | back problems                    |     |    |                                      |     |    |                                 |
|     |    | phlebitis/varicose veins         |     |    |                                      |     |    |                                 |