PATIENT'S PERSONAL HISTORY

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

Last Name: _____ First Name: _____ DOB: _____ DATE: _____

Family History			**If Living**			**If Deceased**
	Age		Health	Age of Death		Cause
Father	_____		_____	_____		_____
Mother	_____		_____	_____		_____
Brothers/Sisters	_____	M/F	_____	_____	M/F	_____
	_____	M/F	_____	_____	M/F	_____
	_____	M/F	_____	_____	M/F	_____
	_____	M/F	_____	_____	M/F	_____
Husband/Wife	_____	M/F	_____	_____	M/F	_____
Sons/Daughters	_____	M/F	_____	_____	M/F	_____
	_____	M/F	_____	_____	M/F	_____
	_____	M/F	_____	_____	M/F	_____
	_____	M/F	_____	_____	M/F	_____

Do you know of any blood relative who has or had:

Illness		Relationship	Illness		Relationship	Illness		Relationship
Stroke	☐	_____	Suicide	☐	_____	Stomach Ulcers	☐	_____
Cancer	☐	_____	Migraine	☐	_____	Kidney Disease	☐	_____
High Blood Pressure	☐	_____	Hay Fever	☐	_____	Goiter	☐	_____
Bleeding Tendency	☐	_____	Colitis	☐	_____	Congenital Heart	☐	_____
Epilepsy	☐	_____	Heart Attack	☐	_____	Nervous Breakdown	☐	_____
Diabetes	☐	_____	Arthritis	☐	_____	Leukemia	☐	_____

Personal Habits:

Yes	No	Do you regularly smoke?	Cigarettes ☐ Pipe ☐ Cigars ☐ # of years ____
Yes	No	Do you usually drink over 6 cups of coffee per day?	
Yes	No	Do you regularly drink alcohol?	1oz ☐ 2oz ☐ 4oz ☐ Over 6oz ☐
		Beer?	1 bottle ☐ 2 bottles ☐ Over 4 bottles ☐
Yes	No	Do you have difficulty in falling asleep?	
Yes	No	Do you awaken early in the morning without apparent cause?	

Medications:

Are you presently taking any of the following medications?

Yes	No	Aspirin, Bufferin	Yes	No	Tranquilizers
Yes	No	Blood pressure pills	Yes	No	Weight reducing pills
Yes	No	Cortisone	Yes	No	Blood thinning pills
Yes	No	Cough Medicine	Yes	No	Dilantin
Yes	No	Digitalis	Yes	No	Water pills
Yes	No	Hormones	Yes	No	Antibiotics
Yes	No	Insulin or Diabetes pills	Yes	No	Barbiturates
Yes	No	Iron	Yes	No	Birth control pills
Yes	No	Laxatives	Yes	No	Phenobarbital
Yes	No	Sleeping pills	Yes	No	Other drugs not listed
Yes	No	Thyroid Medicine			_____

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

_____

_____

Name any drugs to which you are allergic:

_____

_____

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

_____

_____

Serious illnesses which you have had: (not requiring hospitalization)

_____

_____

Serious injuries or accidents:

_____

_____