PHYSICIANS EAST P.A.
PROVIDING COMPREHENSIVE HEALTH CARE TO EASTERN NORTH CAROLINA

PE#
Date:

PERSONAL HISTORY FORM

LAST NAME: _____

FIRST NAME: _____

DATE AND PLACE OF BIRTH: _____

ADDRESS: _____

PHONE: _____ **EMAIL:** _____

ALTERNATE PHONE: _____

CHIEF COMPLAINT: _____

PRIMARY PROVIDER: _____

PAST MEDICAL HISTORY:

- ☐ Asthma
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Bronchitis
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Coronary artery disease
- ☐ High blood pressure
- ☐ HIV
- ☐ Inflammatory bowel disease
- ☐ Kidney disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Prostate disease
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Others
- ☐ _____

PAST SURGERIES: _____

ALLERGIES: _____

SOCIAL HISTORY:

- ☐ Marital status _____
- ☐ Alcohol use _____
- ☐ Tobacco use _____
- ☐ Pack years? _____
- ☐ Year stopped _____
- ☐ Illicit drug use _____
- ☐ Occupation _____
- ☐ Caffeinated drinks

Past blood transfusions?

VACCINATIONS:

- ☐ Flu shot
- ☐ Pneumovax
- ☐ Hepatitis
- ☐ Tetanus
- ☐ Other

FAMILY HISTORY: CHILDREN _____ **SIBLINGS:** _____ **PARENTS:** _____

- ☐ Asthma
- ☐ Bleeding disorder
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Coronary artery disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Osteoarthritis
- ☐ Prostate disease
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Cancer
  - ○ Breast
  - ○ Lung
  - ○ Colon

ADVANCE DIRECTIVES / LIVING WILL: _____ **OTHER:**