

PERSONAL HISTORY FORM

LAST NAME: _____

FIRST NAME: _____

DATE AND PLACE OF BIRTH: _____

ADDRESS: _____

PHONE: _____ **EMAIL:** _____

ALTERNATE PHONE: _____

CHIEF COMPLAINT: _____

PRIMARY PROVIDER: _____

PAST MEDICAL HISTORY:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> HIV | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Inflammatory bowel disease | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Others _____ |
| <input type="checkbox"/> High cholesterol | | <input type="checkbox"/> Prostate disease | |
| <input type="checkbox"/> Diabetes | | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Fibromyalgia | | <input type="checkbox"/> Stroke | |

PAST SURGERIES: _____

ALLERGIES: _____

SOCIAL HISTORY:

- Marital status _____
- Alcohol use _____
- Tobacco use _____
- Pack years? _____
- Year stopped _____

VACCINATIONS:

- Illicit drug use _____
- Occupation _____
- Caffeinated drinks _____

- Flu shot
- Pneumovax
- Hepatitis
- Tetanus
- Other _____

Past blood transfusions? _____

FAMILY HISTORY: CHILDREN _____

- Asthma
- Bleeding disorder
- High cholesterol
- Diabetes
- Coronary artery disease
- High blood pressure

SIBLINGS: _____

- Kidney disease
- Osteoarthritis
- Prostate disease
- Seizures
- Stroke
- Thyroid disease

PARENTS: _____

- Cancer
 - Breast
 - Lung
 - Colon

ADVANCE DIRECTIVES / LIVING WILL: _____

OTHER: _____

