PHYSICIANS EAST, P.A

PROVIDING COMPREHENSIVE HEALTH CARE TO EASTERN NORTH CAROLINA

SURGERY DEPARTMENT

Personal History Form

To help us serve you better, please complete the following information

Chart Number ____________

Date ____________

Personal data:

Last Name	First	Middle	Birth Date	Birth Place
Address	City / State	Zip	Home Phone	Business Phone
			Sex M F	Religion

Reason for visit today: ____________

Personal physician ____________ City: ____________

Who recommended you to us:

____ Physician ____ Friend ____ Relative ____ Advertisement ____ Phone book

Please fill in or check all that apply

Medical History

Please list all medications you currently take and the doses. Include non-prescription medications also.

Medication	Dose	Medication	Dose
____	dose ____	____	dose ____
____	dose ____	____	dose ____
____	dose ____	____	dose ____
____	dose ____	____	dose ____
____	dose ____	____	dose ____
____	dose ____	____	dose ____

List any MEDICAL DISORDERS which YOU have had or are being treated for:

____ Anemia
____ Asthma
____ Bleeding Disorder
____ Bronchitis
____ Cancer (what type) ____________
____ Cholesterol/Lipids
____ Chronic Fatigue Syndrome
____ Chronic Lung Disease
____ Colitis
____ Diabetes
____ Diverticulitis
____ Endometriosis
____ Fibrocystic Breast Disease
____ Fibromyalgia
____ Heart Attack
____ Heart Disease
____ Heart Murmur
____ Hepatitis
____ High Blood Pressure
____ HIV
____ Inflammatory Bowel Disease
____ Infertility
____ Irritable Bowel Syndrome
____ Kidney Disease
____ Kidney Stones
____ Leukemia
____ Lupus
____ Mental Disorder
____ Migraines
____ Osteoporosis
____ Osteoarthritis
____ Prostate Disease
____ Seizures
____ Sexual Dysfunction
____ Stroke
____ Thyroid Disease
____ Tuberculosis
____ Ulcers
____ Other Medical Problems ____________

List any SURGERIES you have had:

____

(Please turn page)

Please list any ALLERGIES you have:

_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________

Social History:

Marital Status: ______ Married ______ Divorced ______ Widowed ______ Single

Occupation ____________________________

Children ______ (number)

Personal Habits:

______ Yes ______ No Do you use tobacco? ______ Cigarettes ______ Pipe ______ Snuff ______ Cigars
For how many years? ______ Packs per day? ______

______ Yes ______ No Do you use alcohol? ______ Wine, Liquor: Ounces ______ per day/week
Beer: Bottles ______ per day/week

______ Yes ______ No Do you drink caffeinated... ______ Coffee ______ Tea ______ Soft Drinks
Cups, glasses or cans per day ______ Coffee ______ Tea ______ Soft Drinks

______ Yes ______ No Do you exercise regularly? (describe) ____________________

______ Yes ______ No Do you use seatbelts when in a vehicle?

______ Yes ______ No Do you use ilicit drugs?

Health Maintenance: **Date of last exam**

______ Yes ______ No Have you had a treadmill test? ______

______ Yes ______ No Have you had your stools checked for blood? ______

Females only:

______ Yes ______ No Have you had a mammogram? ______

______ Yes ______ No Have you had a PAP test? ______

______ Yes ______ No Do you perform routine breast self-exams?

Males only:

______ Yes ______ No Have you had a prostate exam or blood test? ______

______ Yes ______ No Do you examine your testicles regularly?

Vaccinations: (Please check if you have had)

______ Tetanus ______ Rubella ______ PnuemoVax ______ Hepatitis

______ Yes ______ No Have you ever had a blood transfusion?

______ Yes ______ No Do you have a living will or other advanced directive?

Family History:

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

Asthma	______	Heart Disease	______
Bleeding Tendency	______	High Blood Pressure	______
Cancer	______	Kidney Disease	______
Colitis	______	Leukemia	______
Colon Polyps	______	Mental Illness	______
Diabetes	______	Migraine	______
Epilepsy	______	Stroke	______
Goiter	______	Tuberculosis	______

	Age	Alive?	Cause of Death
Father			
Mother			
Siblings			

(Please turn page)

Review of Systems

HEENT

Glaucoma	______ Yes	______ No
Cataracts	______ Yes	______ No
Dentures	______ Yes	______ No
Sinus problems	______ Yes	______ No
TMJ	______ Yes	______ No

HEMATOLOGY

Easy bleeding/bruising	______ Yes	______ No
Anemia	______ Yes	______ No
DVT	______ Yes	______ No
PE	______ Yes	______ No
Chronic venous stasis disease	______ Yes	______ No

ENDOCRINE

Diabetes	______ Yes	______ No
Hypothyroidism	______ Yes	______ No
Hyperthyroidism	______ Yes	______ No

PULMONARY

Asthma	______ Yes	______ No
Sleep apnea	______ Yes	______ No
COPD	______ Yes	______ No
Bronchitis	______ Yes	______ No

CARDIOVASCULAR

Hypertension	______ Yes	______ No
Dyslipidemia	______ Yes	______ No
Chest pain	______ Yes	______ No
History of MI	______ Yes	______ No
History of CHF	______ Yes	______ No
CABG or stents	______ Yes	______ No

GASTROINTESTINAL

GERD	______ Yes	______ No
Ulcers	______ Yes	______ No
Inflammatory bowel disease	______ Yes	______ No
Irritable bowel syndrome	______ Yes	______ No
Constipation	______ Yes	______ No
Diarrhea	______ Yes	______ No
Blood per rectum	______ Yes	______ No

HEPATIC

Fatty Liver	______ Yes	______ No
Cirrhosis	______ Yes	______ No
Hepatitis	______ Yes	______ No

GENITOURINARY

Prostate problems	______ Yes	______ No
Hesitancy	______ Yes	______ No
Dysuria	______ Yes	______ No
Kidney stones	______ Yes	______ No
Stress Incontinence	______ Yes	______ No
Uterus/ovary problems	______ Yes	______ No
Polycystic ovarian disease	______ Yes	______ No
Infertility	______ Yes	______ No
Kidney disease	______ Yes	______ No
Renal Insufficiency/failure	______ Yes	______ No

Review of Systems

RHEUMATOLOGIC

Fibromyalgia ______ Yes ______ No
Chronic pain syndrome ______ Yes ______ No
Lupus ______ Yes ______ No
Scleroderma ______ Yes ______ No
Rheumatoid arthritis ______ Yes ______ No

MUSCULOSKELETAL

Joint pain ______ Yes ______ No
Back pain ______ Yes ______ No
Degenerative joint disease ______ Yes ______ No
Spinal/Disc disease ______ Yes ______ No
Gout ______ Yes ______ No
Osteopenia/Osteoporosis ______ Yes ______ No

NEUROLOGIC

Pseudotumor cerebri ______ Yes ______ No
Migraine headaches ______ Yes ______ No
CVA/TIA ______ Yes ______ No
Seizures ______ Yes ______ No

PSYCHOLOGIC

Depression ______ Yes ______ No
Anxiety ______ Yes ______ No
Bipolar syndrome ______ Yes ______ No
Psychosis/Schizophrenia ______ Yes ______ No
Hospitalization ______ Yes ______ No
Suicide attempt ______ Yes ______ No