PATIENT'S HISTORY FORM

Name ____________________ Age ________ Marital Status S M W D

Date of last physical examination ____________________

PAST HISTORY

Please encircle all answers no or yes

ILLNESSES: Have you ever had

Illness		
Measles	no	yes
German Measles	no	yes
Mumps	no	yes
Chicken pox	no	yes
Whooping cough	no	yes
Scarlet fever or Scarletina	no	yes
Diptheria	no	yes
Smallpox	no	yes
Pneumonia	no	yes
Influenza	no	yes
Pleurisy	no	yes
Rheumatic fever	no	yes
Arthritis or Rheumatism	no	yes
Bone or joint disease	no	yes
Gout	no	yes
Heart disease	no	yes
Polio	no	yes
Meningitis	no	yes
Bright's disease	no	yes
Gonorrhea	no	yes
Syphilis	no	yes
Anemia	no	yes
Jaundice	no	yes
Epilepsy	no	yes
Migraine headache	no	yes
Tuberculosis	no	yes
Sugar in the urine	no	yes
Diabetes	no	yes
Cancer	no	yes
High blood pressure	no	yes
Low blood pressure	no	yes
Liver disease	no	yes
Gallbladder disease	no	yes
Appendicitis	no	yes
Encephalitis	no	yes
Stomach trouble	no	yes
Ulcer	no	yes
Nervous breakdown	no	yes
Food, chemical or drug poisoning	no	yes
Hay fever	no	yes
Asthma	no	yes
Kidney disease or stones	no	yes
Bladder infection	no	yes
Frequent infections or boils	no	yes
Any other disease	no	yes

List ____________________

CURRENT MEDICATIONS:

List ____________________

ALLERGIES: Are you allergic to

Allergy		
Penicillin or sulfa	no	yes
Aspirin, codeine, or morphine	no	yes
Mycins or other antibiotics	no	yes
Merthilate or Mercurochrome	no	yes
Any other drugs	no	yes

List ____________________

Any foods	no	yes

List ____________________

Adhesive tape	no	yes
Nail polish or other cosmetics	no	yes
Tetanus antitoxin	no	yes

INJURIES: Have you had any

Injury		
Broken or cracked bones	no	yes

List ____________________

Sprains	no	yes

List ____________________

Dislocations	no	yes

List ____________________

Lacerations	no	yes

List ____________________

Concussion, head injury	no	yes
Ever been knocked unconscious	no	yes

TRANSFUSIONS: Have you ever had blood or plasma transfusion ______ no yes

SURGERY: Have you had

	Date		
Tonsillectomy ______	______	no	yes
Appendectomy ______	______	no	yes
Hernia ______	______	no	yes
Gallbladder ______	______	no	yes
Stomach ______	______	no	yes
Rectal ______	______	no	yes
Hysterectomy ______	______	no	yes
Breast ______	______	no	yes
Bones ______	______	no	yes

List ______

ANY OTHER SURGERY:

List ______

List ______

List ______

Have you ever been advised to have any surgical operation which has not been done ______ no yes

List ______

Have you been hospitalized for any illnesses ______ no yes

Give details and dates ______

FAMILY HISTORY

		Age	If Living Health	If Deceased Age at Death	Cause
Father					
Mother					
Brother or Sister	1.				
	2.				
	3.				
	4.				
	5.				
Husband or Wife					
Son or Daughter	1.				
	2.				
	3.				
	4.				
	5.				

Has any blood relative ever had:	Please encircle		Who
Cancer	no	yes	
Tuberculosis	no	yes	
Diabetes	no	yes	
Heart trouble	no	yes	
High blood pressure	no	yes	
Gout	no	yes	
Stroke	no	yes	
Epilepsy	no	yes	
Insanity	no	yes	
Suicide	no	yes	

REORDER # 02-13917-30

WEIGHT: Now ________ One year ago ________ Maximum ________ 2 yrs. ago ________

X-RAYS: Have you ever had x-rays of

Chest ________ Date ________ no yes
Stomach or colon ________ Date ________ no yes
Gallbladder ________ Date ________ no yes
Back ________ Date ________ no yes
Other:
List ________

EKG: Ever had an electrocardiogram ________ Date ________ no yes

IMMUNIZATIONS: Have you had

Smallpox vaccination within last 7 years ________ no yes
Tetanus shots (not antitoxin which lasts only 2 weeks) ________ no yes
Polio shots (or oral vaccine) within the last 2 years ________ no yes

ALCOHOLIC BEVERAGES: Never ________ Rarely ________ Moderate ________ Daily ________
Have you ever been treated for alcoholism ________ no yes

TOBACCO: Cigarettes: ________ packs per day
Cigars ________ Pipe ________ Chewing tobacco ________ Snuff ________

DRUGS:

Digitalis (for heart)	never ____	now ____	yes, in the past but none now ____	
Blood pressure pills	never ____	now ____	yes, in the past but none now ____	
Laxatives	never ____	now ____	freq ____	daily ____
Vitamins	never ____	occ ____	freq ____	daily ____
Sedatives	never ____	occ ____	freq ____	daily ____
Tranquilizers	never ____	occ ____	freq ____	daily ____
Sleeping pills, etc	never ____	occ ____	freq ____	daily ____
Aspirin, etc	rarely ____	occ ____	freq ____	daily ____
Cortisone, Acth.	never ____	occ ____	freq ____	daily ____
Thyroid	never ____	yes, in the past but none now ____		
Appetite depressants	never ____	occ ____	freq ____	daily ____

Have you ever been treated for drug habits ________ no yes

RECREATION:
Do you participate in sports or have any hobbies which give you relaxation at least 3 hours weekly ________ no yes
TV ________ hrs. per day
Reading ________ hrs. per week
Vacations ________ per year

Do you have a personal problem you would like to talk over with your doctor ________ no yes

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FOR WOMEN ONLY:
Do you have vaginal bleeding ________ no yes
Do you have a vaginal discharge ________ no yes

MENSTRUAL HISTORY:
Age at onset ________ Regular - Yes ________ No ________ cycle ________ day
Usual duration ________ days, ________ heavy ________ medium ________ light ________ pain or cramps no yes
Date of last menstrual period ________

PREGNANCIES:
How many children born alive ________ How many stillbirths ________
How many prematures ________ How many miscarriages ________
Any complications with pregnancy ____ yes ____ no
Are you pregnant now ____ yes ____ no

INVENTORY OF SYSTEMS

GASTROINTESTINAL - Do you now have or have you ever had

Indigestion ________ no yes
Constipation ________ no yes
Diarrhea ________ no yes
Black stools ________ no yes
Has there been any recent change in
your appetite or eating habits ________ no yes
your bowel action or stools ________ no yes
White or clay colored stools ________ no yes
Nausea ________ no yes
Vomiting ________ no yes
Vomiting blood ________ no yes
Trouble swallowing ________ no yes
Abdominal ache or pain ________ no yes
Trouble eating greasy, spicy or raw foods ________ no yes
Excessive bloating ________ no yes
Excessive gas ________ no yes
Gas ________ no yes
Bowels move regular ________ no yes

GENITO-URINARY - Do you now have or have you ever had

Frequent night urination ________ no yes
Too frequent urination ________ no yes
Abnormal thirst ________ no yes
Burning, itching, etc. on urination ________ no yes
Difficulty urinating ________ no yes
Albumin, sugar, pus, etc. in urine ________ no yes

CARDIO-VASCULAR - Do you now have or have you ever had

Chest pain ________ no yes
Angina pectoris ________ no yes
Spitting up blood ________ no yes
Cough ________ no yes
Shortness of breath ________ no yes
Palpitation or Fluttering of the heart ________ no yes
Swelling of hands, feet or ankles ________ no yes
Varicose veins ________ no yes

NEURO-MUSCULAR - Do you now have or have you ever had

Fainting spells ________ no yes
Loss of consciousness ________ no yes
Convulsions ________ no yes
Tremors or shakes ________ no yes
Paralysis ________ no yes
Change in ability to walk ________ no yes
Dizziness ________ no yes
Loss of coordination ________ no yes
Frequent or severe headaches ________ no yes
Backache ________ no yes
Depression ________ no yes
Anxiety ________ no yes
Ringing or buzzing in ears ________ no yes
Extreme tiredness or weakness ________ no yes
Pain or cramps in legs ________ no yes
Pain or aches in joints or muscles ________ no yes
Any eye disease, injury, impaired sight ________ no yes
Any ear disease, injury, impaired hearing ________ no yes

RESPIRATORY - Do you now have or have you ever had

Wheezing breath sounds ________ no yes
Nights sweats ________ no yes
Chest pain ________ no yes
Cough ________ no yes
Spitting up blood ________ no yes
Shortness of breath ________ no yes
Any trouble with nose, sinuses, mouth, throat ________ no yes
List ________

METABOLIC: Poor intolerance of heat or cold ________ no yes

ENDOCRINE AND LYMPHATICS - Do you now have or have you ever had

Enlarged glands ________ no yes
Change in hair, nails, or skin ________ no yes
Enlarged thyroid ________ no yes
Goiter ________ no yes
Skin disease ________ no yes