

**PATIENT'S PERSONAL HISTORY FORM**

THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN THIS OFFICE. THE INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

SYMPTOMS: \_\_\_\_\_

WAS THIS AN INJURY?            YES / NO                            DATE OF INJURY: \_\_\_\_\_

FAMILY DOCTOR:: \_\_\_\_\_ REFERRING DOCTOR \_\_\_\_\_

**PAST MEDICAL HISTORY:** Do you have, or have you ever had, any of the following illnesses? :

- |                       |          |    |   |
|-----------------------|----------|----|---|
| Cancer                | Yes / No | => | Type of cancer / Medications used _____         |
| Diabetes              | Yes / No | => | Type of diabetes / Medications used _____       |
| Heart Problems        | Yes / No | => | Type of heart problems / Medications used _____ |
| Stroke                | Yes / No |    |   |
| Polio                 | Yes / No |    |   |
| Lung Disease          | Yes / No | => | Type of disease / Medications used _____        |
| Ulcers                | Yes / No |    |   |
| Gallbladder Disease   | Yes / No |    |   |
| Jaundice              | Yes / No |    |   |
| Kidney Disease        | Yes / No |    |   |
| Bone or Joint Disease | Yes / No |    |   |
| High Blood Pressure   | Yes / No | => | Medications used _____                          |
| Thyroid Problems      | Yes / No | => | Medications used _____                          |
| Hay fever             | Yes / No | => | Medications used _____                          |
| Asthma                | Yes/No   | => | Medications used _____                          |

List all Hospitalizations (What type, When, Where) \_\_\_\_\_

List all Operations (What type, When, Where) \_\_\_\_\_

**ALLERGIES:** (Please circle) Penicillin, Sulfa, Aspirin, Codeine, Demerol, Morphine, Merthiolate, Mercurochrome, Other (please state symptoms)

Adhesive tape, Latex, any foods (please state) \_\_\_\_\_

If Yes What are the your symptoms: \_\_\_\_\_

Do you use tobacco?            Yes / No

Do you use alcohol?            Yes / No

List all prescription medications currently taking including dosage and frequency: \_\_\_\_\_

List all natural supplements currently taking: \_\_\_\_\_

**REVIEW OF SYSTEMS:** Do you have, or have you had, problems with any of the following?

HEAD AND NECK

Frequent Headaches	Yes/No
Dizziness	Yes/No
Double Vision	Yes/No
Hearing Impairment	Yes/No
Sinus Trouble	Yes/No
Teeth	Yes/No
Throat	Yes/No

G.I.

Blood in stools or tarry stools	Yes/No
Vomiting Blood	Yes/No
Stomach Pains	Yes/No
Frequent indigestion	Yes/No
Diarrhea	Yes/No

G.U

Blood in urine	Yes/No
Frequency of urination	Yes/No
Pain with urination	Yes/No
Frequent kidney infections	Yes/No

CNS

Loss of balance	Yes/No
Fainting spells	Yes/No
Paralysis	

CARDIO-RESPIRATORY

Chest pain	Yes/No
Cough up blood	Yes/No
Shortness of Breath	Yes/No
Fluttering of the heart	Yes/No
Ankle/foot swelling	Yes/No

MUSCULOSKELETAL

Arm/leg weakness	Yes/No	
Bone or joint disease	Yes/No	
Muscle disease	Yes/No	
Any broken bones	Yes/No	What and when

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