PHYSICIANS EAST P.A

PROVIDING COMPREHENSIVE HEALTH CARE TO EASTERN NORTH CAROLINA

Personal History Form Chart Number _____

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

Personal data:

Last Name	First	Middle	Birth Date	Birth Place

Address	City	State	Zip	Home Phone	Business Phone

Sex] Religion

Reason for visit today: _____

Personal physician _____ City: _____

Who recommended you is:

_ _ 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.

_____ 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:

Do you suffer from, frequently experience or notice:

Constitutional

Yes ___ No ___ fevers/shaking chills?
Yes ___ No ___ a change in your weight?
Yes ___ No ___ excessive fatigue or weakness?

Renal / Urinary

Yes ___ No ___ burning when urinating?
Yes ___ No ___ loss of control of bladder?
Yes ___ No ___ blood in the urine?
Yes ___ No ___ trouble starting to urinate?
Yes ___ No ___ trouble holding the urine?
Yes ___ No ___ getting up frequently at night?
Yes ___ No ___ passed a kidney stone?

Endocrine

Yes ___ No ___ do you have excessive thirst or need to urinate frequently?
Yes ___ No ___ do you feel excessively anxious?
Yes ___ No ___ are you sensitive to heat or cold?

Lung / Pulmonary

Yes ___ No ___ hoarseness or change in your voice?
Yes ___ No ___ do you snore excessively or loudly?
Yes ___ No ___ a chronic cough or sputum production?
Yes ___ No ___ coughing up blood?

Yes ___ No ___ shortness of breath?

If **yes** please circle:

Yes No doing your usual work?
Yes No climbing a flight of stairs?
Yes No which awakens you at night?
Yes No which causes you to cough?
Yes No accompanied by wheezing?

Skin / Integument

Yes ___ No ___ have you noticed any changes in any warts or moles on your skin?
Yes ___ No ___ do you bruise easily?
Yes ___ No ___ have you noticed any new skin spots, rashes or sores?
Yes ___ No ___ do you have dry, scaly skin?

Rheumatologic

Yes ___ No ___ joints or muscles ache frequently?
Yes ___ No ___ frequent joint swelling or redness?
Yes ___ No ___ chronically dry eyes or mouth?
Yes ___ No ___ pain in your great toe?

Hematologic

Yes ___ No ___ bruise or bleed easily?
Yes ___ No ___ noticed any lymph node swelling or enlargement?
Yes ___ No ___ frequent nosebleeds or bleeding from your gums?

Neurologic

Yes ___ No ___ numbness, weakness or tingling in your muscles or extremities?
Yes ___ No ___ frequent headaches?
Yes ___ No ___ changes in your vision?
Yes ___ No ___ ringing or pain in your ears or hearing loss?
Yes ___ No ___ frequent dizziness or seizures?

Psychologic

Yes ___ No ___ trouble falling asleep or staying asleep?
Yes ___ No ___ do you feel depressed, lonesome or excessively worried for no reason?
Yes ___ No ___ do you ever think of hurting yourself or others?
Yes ___ No ___ do you feel like you have an alcohol or drug dependency problem?
Yes ___ No ___ are you unhappy with your life?

Cardiovascular

Yes ___ No ___ fluid retention in your feet or legs?
Yes ___ No ___ frequent cramps in your legs at rest or while walking?
Yes ___ No ___ varicose veins or phlebitis?
Yes ___ No ___ palpitations or an irregular heart rate?

Yes ___ No ___ chest pain, tightness or pressure?

If **yes** please circle:

Yes No when exerting yourself?
Yes No radiates to the arm or neck?
Yes No disappears if you rest?
Yes No after a heavy meal?
Yes No when upset or excited?
Yes No when walking in cold weather?

(Please turn page)

Gastrointestinal

Yes ___ No ___ a loss of appetite?
Yes ___ No ___ trouble swallowing?
Yes ___ No ___ frequent nausea or vomiting?
Yes ___ No ___ frequent heartburn?
Yes ___ No ___ frequent mouth sores or tongue irritation?
Yes ___ No ___ pain after meals, or after eating fried or spicey foods?
Yes ___ No ___ pain relieved by antacids or medication like Zantac or Pepcid?
Yes ___ No ___ a change in your bowel habits?
Yes ___ No ___ crampy pain in the abdomen?
Yes ___ No ___ alternating diarrhea and constipation?
Yes ___ No ___ pain during or after bowel movement?
Yes ___ No ___ mucous in the stool?
Yes ___ No ___ blood in the stool or black stools?
Yes ___ No ___ ribbon-like stools?

How often do you have a bowel movement? _____ time(s) per day/week

Genital

To be answered by MEN only: **Have you ever had...**

Yes ___ No ___ loss of sexual activity/desire?
Yes ___ No ___ treatment for genitals (private parts)?
Yes ___ No ___ discharge from penis?
Yes ___ No ___ hernia (rupture)?
Yes ___ No ___ prostate trouble?

To be answered by WOMEN only: **Have you ever had...**

Yes ___ No ___ loss of sexual activity/desire?
Yes ___ No ___ are you still having regular periods?
Yes ___ No ___ do you have bleeding between your periods?
Yes ___ No ___ do you have very heavy bleeding with your periods?
Yes ___ No ___ do you use birth control?
Yes ___ No ___ do you have a discharge from the nipple of your breast?
Yes ___ No ___ do you have a vaginal discharge?

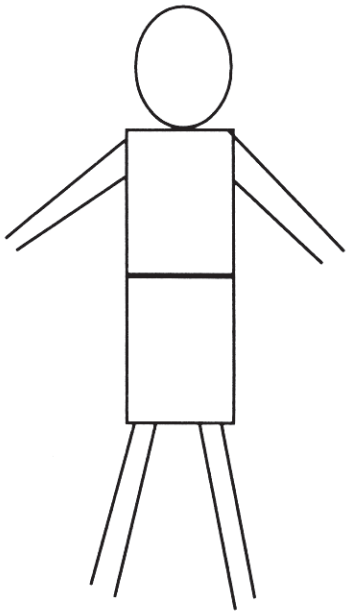
How many children born alive _____
How many stillbirths or miscarriages _____
Date of last menstrual period _____
Any complication of pregnancy _____

For staff use only

Notes:

Labs / Tests:

Plan:



For staff use only

Vital signs (sit) BP / HR _____

(stand) BP / HR _____

Wt: _____ Temp: _____

Gen:
Lymph
Head / Neck / Oral
Thyroid
Chest
Cor
Abd
Genital/Urinary
Rectal
Neuro
Musculoskeletal
Skin

Reviewed by: _____