PHYSICIANS EAST, P.A.

PROVIDING COMPREHENSIVE HEALTH CARE TO EASTERN NORTH CAROLINA

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	**Religion**

Reason for visit today: _____

Personal Physician _____ City: _____

Who recommended you?

☐ Physician ☐ Friend ☐ Relative ☐ Advertisement ☐ Phone Book

Medical History

Please list all medications you currently take and the doses, include non-prescription medications.

_____ dose _____ _____ dose _____

_____ dose _____ _____ dose _____

_____ dose _____ _____ dose _____

_____ dose _____ _____ dose _____

_____ dose _____ _____ dose _____

_____ dose _____ _____ dose _____

Please fill in or check all that apply

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 illicit/non-prescribed drugs?

☐ Yes ☐ No Are you exposed to second-hand smoke?

Health Maintenance: **Date of last exam**

☐ Yes ☐ No Have you had a treadmill test? _____

☐ Yes ☐ No Have you had a screening for colon cancer? _____

☐ Yes ☐ No Do you receive regular eye exams? _____

☐ Yes ☐ No Do you receive regular dental care visits? _____

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 ☐ Shingles/Zostavax

☐ 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/Substance Abuse	_____
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?*

** If **yes**, depression scale should be done.*

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 spicy 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 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: _____

Special Communication Needs _____Yes _____No

If yes, specify: _____

Reviewed by: _____

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