

PERSONAL HISTORY FORM

LAST NAME: _____

FIRST NAME: _____

DATE AND PLACE OF BIRTH: _____

ADDRESS: _____

PHONE: _____ **EMAIL:** _____

ALTERNATE PHONE: _____

CHIEF COMPLAINT: _____

PRIMARY PROVIDER: _____

PAST MEDICAL HISTORY:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> HIV | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Inflammatory bowel disease | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Others |
| <input type="checkbox"/> High cholesterol | | <input type="checkbox"/> Prostate disease | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Fibromyalgia | | <input type="checkbox"/> Stroke | |

PAST SURGERIES: _____

ALLERGIES: _____

SOCIAL HISTORY:

- ☐ Marital status _____
- ☐ Alcohol use _____
- ☐ Tobacco use _____
- ☐ Pack years? _____
- ☐ Year stopped _____

VACCINATIONS:

- ☐ Illicit drug use _____
- ☐ Occupation _____
- ☐ Caffeinated drinks _____

- ☐ Flu shot
- ☐ Pneumovax
- ☐ Hepatitis
- ☐ Tetanus
- ☐ Other

Past blood transfusions? _____

FAMILY HISTORY: CHILDREN _____

SIBLINGS: _____

PARENTS: _____

- ☐ Asthma
- ☐ Bleeding disorder
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Coronary artery disease
- ☐ High blood pressure

- ☐ Kidney disease
- ☐ Osteoarthritis
- ☐ Prostate disease
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease

- ☐ Cancer
 - ☐ Breast
 - ☐ Lung
 - ☐ Colon

ADVANCE DIRECTIVES / LIVING WILL: _____ **OTHER:** _____

PE#

Date:

REVIEW OF SYSTEMS

DO YOU SUFFER FROM, FREQUENTLY EXPERIENCE OR NOTICE: PLEASE MARK AS APPLY

Constitutional:

- ☐ Fever/shaking chills
- ☐ Change in weight
- ☐ Excessive fatigue or weakness

Lung/Pulmonary:

- ☐ Hoarseness or change in voice
- ☐ Chronic cough or sputum production
- ☐ Coughing up blood
- ☐ Shortness of breath
 - ☐ Doing your usual work
 - ☐ Climbing a flight of stairs
 - ☐ Which awakens you at night
 - ☐ Which causes you to cough
 - ☐ Accompanied by wheezing

Sleep:

- ☐ Sleepiness in daytime
- ☐ Snore excessively or loudly
- ☐ Sleep paralysis
- ☐ Restless legs
- ☐ Drop attacks
- ☐ Hallucinations upon awakening
- ☐ Paralysis upon awakening

Cardiovascular:

- ☐ Fluid retention in feet or legs
- ☐ Frequent cramps in legs at walking
- ☐ Varicose veins or phlebitis
- ☐ Palpitations or irregular heartbeat
- ☐ Chest pain, tightness or pressure
 - ☐ When exerting yourself
 - ☐ Radiates to arm or neck
 - ☐ Disappears if you rest
 - ☐ After a heavy meal
 - ☐ When upset or excited
 - ☐ When walking in cold weather

Gastrointestinal:

- ☐ Loss of appetite
- ☐ Trouble swallowing
- ☐ Frequent heartburn
- ☐ Pain after meals or spicy foods
- ☐ Pain relieved by antacids

Renal-Urinary:

- ☐ Loss of control of bladder
- ☐ Blood in urine
- ☐ Getting up frequently at night

Endocrine:

- ☐ Do you have excessive thirst
- ☐ Do you feel anxious
- ☐ Are you sensitive to cold

Rheumatologic:

- ☐ Joints or muscles ache frequently
- ☐ Frequent joint swelling or redness
- ☐ Chronically dry eyes or mouth

Hematologic:

- ☐ Noticed lymph node swelling or enlargement
- ☐ Frequent nosebleeds
- ☐ History of anemia

Psychologic:

- ☐ Trouble sleeping
- ☐ Depressed, lonesome or worried
- ☐ Alcohol-drug dependency problem
- ☐ Unhappy with your life

Neurologic:

- ☐ Numbness, weakness or tingling
- ☐ Frequent headaches
- ☐ Dizziness

Genital:

- ☐ Loss of sexual activity/desire
- ☐ Still having regular periods
- ☐ Do you use birth control
- ☐ Prostrate trouble
- ☐ Hernia trouble

Skin:

- ☐ Noticed any changes in warts or moles
- ☐ Do you bruise easily
- ☐ Noticed new skin spots, rashes or sores
- ☐ Dry, scaly skin

SLEEP QUESTIONNAIRE

How long have you had a problem with your sleep? _____

Do you consider your sleep problem to be:

mild moderate severe

Do any family members have a sleep problem?

yes no

Do you work shifts?

split shift rotating shift night shift

Sleep Schedule

Normal bedtime on weekday: _____

Normal wakeup time on weekday: _____

Normal bedtime on weekend: _____

Normal wakeup time on weekends: _____

Do you wake up during the night?

yes no

Do you wake up to go to the bathroom?

yes no

Do you wake up early in the morning?

yes no

Do you have difficulty falling asleep?

yes no

Do you have difficulty staying asleep?

yes no

Do you have difficulty waking up?

yes no

Do you nap during the:

day evening How long? _____

Do you dream when you nap?

yes no

Do you have excessive daytime sleepiness?

yes no

Do you have morning headaches?

yes no

Do you awaken short of breath?

yes no

Do you have nighttime heartburn?

yes no

Do you snore?

yes no

Do others complain of your snoring?

yes no

Have you ever awakened.....

Have you ever awakened choking and gasping for air?

yes no

Have you ever awakened with your heart beating irregularly?

yes no

Have you ever awakened from sweating excessively?

yes no

Others observe breathing problems?

yes no

Do you fall asleep.....

Do you fall asleep during the day?

yes no

Do you fall asleep during physical effort?

yes no

Do you fall asleep involuntarily?

yes no

Do you fall asleep while laughing?

yes no

Do you fall asleep while crying?

yes no

Do you feel unable to move when waking up or falling asleep?

yes no

Experience vivid dream-like scenes upon awakening or falling asleep?

yes no

Have trouble at work/school because of sleepiness?

yes no

Do you.....

Do you have nightmares?

yes no

Do you feel sad or depressed?

yes no

Do you feel afraid to go to sleep?

yes no

Do you remember dreams?

yes no

Do you have anxiety?

yes no

Do you feel you won't be able to sleep?

yes no

Do you kick during the night?

yes no

Do you have body pain at night?

yes no

Do you have jaw pain?

yes no

Do you have leg pain?

yes no

Do you have crawling/aching feeling in your legs?

yes no

When you wake up, do you.....

When you wake up, do you feel stiff?

yes no

When you wake up, do you have a dry mouth?

yes no

When you wake up, do you have sore achy muscles?

yes no

When you wake up, do you feel tired?

yes no