

Referring Physician:
Patient Acct. #:

PCP: _____
Age: _____ Date: _____

PATIENT NAME

M

F

PATIENT'S PERSONAL HISTORY

Confidential Record: Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your physician in decisions regarding your care.

01. List any operations or serious illnesses that you have had.

P A S T	a) _____
	b) _____
	c) _____
	d) _____

02. Have you or your immediate family (father, mother, siblings) ever had:

	PATIENT		FAMILY	
S	a) Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
T	b) Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
O	c) High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
R	d) Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Y	e) Congenital Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	f) Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	g) Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	h) Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

R 03. Do you now have or in the past 6 months experienced lightheadedness or dizziness? Yes No

E **V** 04. Chest pain? (a) with exertion? Yes No **or** (b) at rest? Yes No

I 05. Shortness of breath? (a) with exertion? Yes No **or** (b) at rest? Yes No

E 06. Wake from sleep because of shortness-of-breath? Yes No

W 07. Pain or swelling in legs? Yes No

OF 08. Sleeplessness or tiredness? Yes No

S 09. Sleep with head elevated to facilitate breathing? Yes No

Y 10. Do you have (a) headaches? Yes No

S (b) visual problems? Yes No

T 11. Passed out in the past year? Yes No

E 12. Ringing in your ears? Yes No

M
S 13. When was your last menstrual period? _____

PLEASE COMPLETE REVERSE SIDE



PATIENT'S PERSONAL HISTORY (SIDE 2)

M E D I C A T I O N S	14. List any medications that you are presently taking:			
	Medication	Dosage	Medication	Dosage
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

S O C I A L	15. Do you have any drug or food allergies?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, list the drugs or foods:
	_____			_____	_____	_____
	_____			_____	_____	_____
	_____			_____	_____	_____
	_____			_____	_____	_____

H I S T O R Y	16. Have you ever used tobacco products?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	# of Years: _____
	17. Do you currently use tobacco products?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	# Per Day: _____
	18. Do you drink coffee, tea or any caffeine beverages?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	# of Cups Per Day _____
	19. Do you regularly drink beer, wine or liquor?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	# of Drinks Per Day _____
	20. Have you ever had a drug problem or are you using recreational drugs now?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
21. Occupation: _____						
22. Do you work unusually hard or long hours?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	How many hours per week _____	
23. Is there much tension or pressure in your job?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
24. Marital Status (Please Circle):			Single	Married	Widow	Divorced Separated
25. Do you live alone?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		

To Be Completed By Nurse

C U R R E N T	26. What is your reason for seeing the doctor? _____	

27. How long have you had this problem? _____		
28. What other health complaints do you have? _____		