

# Patient Personal History

Name: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Birthplace \_\_\_\_\_ Date of last exam \_\_\_\_\_

**ALLERGIES:**

**MAIN PROBLEMS/ REASONS FOR THIS APPOINTMENT:** (if possible, rank in terms of importance to you)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Additional problems or concerns you would like addressed:

\_\_\_\_\_

\_\_\_\_\_

\*Note: we may not be able to address every problem during the course of one visit.

Current Medications	Dose	Times / Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PAST MEDICAL, SURGICAL & TRAUMA HISTORY** Patient Name: \_\_\_\_\_

List prior illness, injury, hospitalization, surgery, and/or trauma:  
Reason: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
Irritable Bowel Syndrome							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other _____							

## SOCIAL HISTORY (check those that apply):

Patient Name: \_\_\_\_\_

Marital status:

- single  
 married  
 divorced  
 Widowed

Education level completed:

- high school  
 college  
 professional school  
 other: \_\_\_\_\_

Memories of your childhood

- Mostly happy  
 Mostly painful  
 Normal  
 don't recall

Do You Find Your Life

- Unsatisfactory  
 Too Demanding  
 Boring  
 Satisfactory

Living arrangement:

- alone  family  roommate  significant other

children (list sex/ages): \_\_\_\_\_

Major stresses in last 6 months  Money  Job  Marriage  Home Life  Children

other stressors \_\_\_\_\_

**Pertinent travel history:** \_\_\_\_\_ (out of USA, epidemic areas)

**LIFESTYLE / SELF-CARE ISSUES**

Do you smoke cigarettes?  YES  NO If yes, how many? # \_\_\_\_\_ yrs. \_\_\_\_\_ packs/day  
 Did you ever smoke?  YES  NO If yes, when did you quit? \_\_\_\_\_  
 Do you drink alcohol?  YES  NO If yes, how much? Type \_\_\_\_\_ & \_\_\_\_\_ drinks/wk  
 Do you drink caffeinated beverages?  YES  NO If yes, which? \_\_\_\_\_  
 Do you use recreational drugs?  YES  NO If yes, which? \_\_\_\_\_  
 Do you manage stress well?  YES  NO  NOT SURE  NEED HELP  
 Do you exercise regularly?  YES  NO If no, why? \_\_\_\_\_  
 Do you enjoy your job?  YES  NO If no, why? \_\_\_\_\_  
 Do you allow time to unwind and relax?  YES  NO If no, why? \_\_\_\_\_  
 Do you sleep soundly?  YES  NO If no, why? \_\_\_\_\_  
 Are you satisfied with your sex life?  YES  NO If no, why? \_\_\_\_\_  
 Are you satisfied with your social life?  YES  NO If no, why? \_\_\_\_\_  
 Are you satisfied with your spiritual life?  YES  NO If no, why? \_\_\_\_\_  
 Is your diet healthy enough?  YES  NO  NOT SURE  NEED HELP

Typical breakfast \_\_\_\_\_  
 Typical lunch \_\_\_\_\_  
 Typical dinner \_\_\_\_\_

Do you use any of the following?  
 \_\_\_ Eyeglasses      \_\_\_ Contact Lens      \_\_\_ Hearing Aid      \_\_\_ Dentures  
 \_\_\_ Brace (Neck, Back)      \_\_\_ Pacemaker      \_\_\_ IUD, Diaphragm      \_\_\_ Artificial Limbs

**HEALTH SCREENING HISTORY** Patient Name: \_\_\_\_\_

List the date of your most recent test or exam.  
 Mammogram \_\_\_\_\_ Pap Smear \_\_\_\_\_ Self Breast Exam \_\_\_\_\_ Breast Exam by Doctor \_\_\_\_\_  
 Blood test for Cholesterol \_\_\_\_\_ Blood Sugar \_\_\_\_\_ Other Blood tests \_\_\_\_\_  
 Immunizations: Polio \_\_\_\_\_ Tetanus \_\_\_\_\_ Hepatitis \_\_\_\_\_ Pneumonia \_\_\_\_\_ Flu Shot \_\_\_\_\_  
 Test for Blood in stool \_\_\_\_\_ Rectal Exam \_\_\_\_\_ Feeling the Prostate \_\_\_\_\_ Scope Lower bowel \_\_\_\_\_  
 Self Exam Testicle \_\_\_\_\_ Testicle Exam by Professional \_\_\_\_\_

Anatomy/Procedure	X-ray	MRI	CT Scan	Ultrasound	Bone Scan	Pet Scan	EMG
Back							
Brain							
Chest							
Colon							
Extremities (Arm/ Leg)							
Gallbladder							
Kidney							
Neck							
Pelvis							
Stomach							
Other							

This history record has been designed to facilitate our patients' continuity of care at The Medical Center of Elberton. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.

\_\_\_\_\_  
 Patient/Guardian signature that filled out the history      Date