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