All of the following Questions must be answered for treatment in this Office:

PERSONAL HISTORY QUESTIONNAIRE

Date: ____/____/____

Last Name: ____________________ **First:** ________________ **MI:** ____ **ID #** ______

Birth Date: ____/____/____ ☐Married, ☐Remarried, ☐Divorced, ☐Separated, ☐Widowed, ☐Single

Age: ____ **Education:** Highest Level ________ **Occupation:** ______________ **How Long:** ______

Occupation of Spouse: ________________ **My Last 2 Week Vacation:** __________

How many Children: ______ **Ages:** ____________________ **Their Health:** ________

Women - Pregnant: ☐Yes ☐No; **Planning Pregnancy:** ☐Yes ☐No; **Oral Contraceptives:** ☐Yes ☐No

Last Period: ____/____/____, **Periods:** ☐Regular ☐Irregular; **Age Periods Started:** _____

Last Pap: _____ **Last Mammogram:** ______ **Miscarriages #** ____ **Menopause at Age:** _____

Mark Any Chronic Conditions or Illnesses You Have Had: ☒

☐Measles ☐Chicken Pox ☐Mumps ☐Diphtheria ☐Scarlet Fever ☐Rheumatic Fever ☐Whooping Cough ☐Eye or Hearing Problems ☐Glaucoma
☐Thyroid Problems ☐Headaches ☐Migraine ☐Depression ☐Panic ☐Seizures ☐Asthma ☐Chronic Cough ☐Shortness of Breath ☐Pneumonia ☐TB
☐Chest Pains ☐Heart Trouble ☐High Blood Pressure ☐Stroke ☐Bleeding /Anemia ☐Vein Trouble ☐Heartburn/Ulcer/Stomach ☐Diabetes ☐Jaundice
☐Diarrhea ☐Constipation ☐Blood in Stool or Urine ☐Kidney /Bladder ☐Joint or Back Pains ☐Osteoporosis ☐Abnormal Mammogram ☐Abnormal Pap
☐Cancer ☐Syphilis ☐HIV ☐HIV Risk Factors ☐Gonorrhea ☐Herpes ☐Other __________

☐Blood Transfusion: If So, When: ________ Present Weight: ________ How Long at This Weight ? ________

Last Exam: Physical: ______ Eye: ______ Dental: ______ Stool for Blood: ______ Prostate: ______

Operations: (like tonsils, appendix, hysterectomy,...)

1) ____________________ Yr. ______ 2) ____________________ Yr. ______
3) ____________________ Yr. ______ 4) ____________________ Yr. ______

Major Injuries: (fracture, concussion,...) ____________________________ Yr. ______

☐Smoke: Packs/Day ______
Year Started ______
When Stopped ______
☐Exercise Routine: ______

☐Coffee: Cups/Day ______
other caffeine ______
☐Alcohol: Type/Amount ______
☐Diet: Salt intake ______
Fat intake ______

☐Sleep: Difficulty falling asleep ______
Continuity problems ______
Snoring ______
Early Morning Waking ______
Daytime Drowsiness ______

☐Contact at work with: Chemicals ____ Blood or body fluids ____

Medicines You Take Now: (blood pressure, birth control,...)

____
____
____
____

Medicine Allergies: ☐Penicillin ☐Sulfa ☐Other ______
____

Other Allergies: (pollens, foods,..) ______________
____

Father: age ____ ☐deceased: cause __________
Mother: age ____ ☐deceased: cause __________

Reason for Today's Visit: ______________
____
____

Family History: ✓

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Convulsions	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐
Bleeding /Anemia	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Disease	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Patient's Signature: ____________________________