Print Form

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

Personal History Questionnaire

Date: _____

Last name: _____ First Name: _____ MI: _____

DOB: _____ ☐ Married ☐ Remarried ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Age: ___ Education: (Highest level) _____ Occupation: _____ How Long: _____

Occupation of Spouse: _____ My last two 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:

☐ Migraines ☐ Depression ☐ Panic attacks ☐ Seizures ☐ Asthma ☐ Chronic Cough ☐ Shortness of breath

☐ Pneumonia ☐ TB ☐ High blood pressure ☐ Stroke ☐ Bleeding/Anemia ☐ Vein trouble ☐ Joint or back pains

☐ Abnormal Mammogram ☐ Heartburn/Ulcer/Stomach ☐ Diabetes ☐ Jaundice ☐ Diarrhea ☐ Constipation

☐ Kidney/Bladder ☐ Heart trouble ☐ Blood in stool or Urine ☐ Chest Pains ☐ Cancer ☐ Osteoporosis

☐ Abnormal Pap ☐ 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: (i.e. tonsil removal, appendectomy, hysterectomy, arthroscopic surgery...)

1) _____ Yr. _____ 2) _____ Yr. _____

3) _____ Yr. _____ 4) _____ Yr. _____

Major Injuries:(fracture, concussion, ...) _____ Yr. _____

☐ Smoke: Packs/Day _____ ☐ Coffee: Cups/Day _____ ☐ Sleep: Difficulty Falling asleep _____

Year Started _____ Other caffeine _____ Continuity problems _____

When stopped _____ ☐ Alcohol: Type/Amount _____ Snoring _____

☐ Exercise routine _____ ☐ Diet: Salt intake _____ Early morning waking _____

_____ Fat intake _____ Daytime Drowsiness _____

☐ Contact at work with: Chemicals_____ Blood or body fluids _____

Medications you take now (blood pressure, birth control, ...)

_____

_____

_____

Medication allergies: ☐ Penicillin ☐ Sulfa ☐ Other

_____

_____

_____

Other allergies: (pollen, foods, pets, ...)

_____

_____

_____

Father: age _____ ☐ deceased: cause _____

Mother: age _____ ☐ deceased: cause _____

Reason for today's visit:

_____

_____

Family History

	Father	Mother	Father's Parents's	Mother 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 Illness	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Patient's Signature _____