PHYSICIANS EAST P.A

PROVIDING COMPREHENSIVE HEALTH CARE TO EASTERN NORTH CAROLINA

SURGERY DEPARTMENT

Personal History Form

To help us serve you better, please complete the following information

Chart Number _____

Date _____

Personal data:

Last Name	First	Middle	Birth Date	Birth Place
Address	City	State / Zip	Home Phone	Business Phone
			Sex M F	Religion

Reason for visit today: _____

Personal physician _____ City: _____

Who recommended you to us:

_____ Physician _____ Friend _____ Relative _____ Advertisement _____ Phone book

Please fill in or check all that apply

Medical History

Please list all medications you currently take and the doses. Include non-prescription medications also.

_____ dose _____ _____ dose _____

_____ dose _____ _____ dose _____

_____ dose _____ _____ dose _____

_____ dose _____ _____ dose _____

_____ dose _____ _____ dose _____

_____ dose _____ _____ dose _____

List any MEDICAL DISORDERS which YOU have had or are being treated for:

_____ Anemia
_____ Asthma
_____ Bleeding Disorder
_____ Bronchitis
_____ Cancer (what type) _____
_____ Cholesterol/Lipids
_____ Chronic Fatigue Syndrome
_____ Chronic Lung Disease
_____ Colitis
_____ Diabetes
_____ Diverticulitis
_____ Endometriosis
_____ Fibrocystic Breast Disease
_____ Fibromyalgia
_____ Heart Attack
_____ Heart Disease
_____ Heart Murmur
_____ Hepatitis
_____ High Blood Pressure
_____ HIV
_____ Inflammatory Bowel Disease
_____ Infertility
_____ Irritable Bowel Syndrome
_____ Kidney Disease
_____ Kidney Stones
_____ Leukemia
_____ Lupus
_____ Mental Disorder
_____ Migraines
_____ Osteoporosis
_____ Osteoarthritis
_____ Prostate Disease
_____ Seizures
_____ Sexual Dysfunction
_____ Stroke
_____ Thyroid Disease
_____ Tuberculosis
_____ Ulcers
_____ Other Medical Problems

List any SURGERIES you have had:

_____

_____

_____

_____

_____

_____

_____

_____

(Please turn page)

Please list any ALLERGIES you have:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History:

Marital Status: _____ Married _____ Divorced _____ Widowed _____ Single

Occupation _____

Children _____ (number)

Personal Habits:

_____ Yes _____ No Do you use tobacco? _____ Cigarettes _____ Pipe _____ Snuff _____ Cigars
For how many years? _____ Packs per day? _____

_____ Yes _____ No Do you use alcohol? _____ Wine, Liquor: Ounces _____ per day/week
Beer: Bottles _____ per day/week

_____ Yes _____ No Do you drink caffeinated... _____ Coffee _____ Tea _____ Soft Drinks
Cups, glasses or cans per day _____ Coffee _____ Tea _____ Soft Drinks

_____ Yes _____ No Do you exercise regularly? (describe) _____

_____ Yes _____ No Do you use seatbelts when in a vehicle?

_____ Yes _____ No Do you use ilicit drugs?

Health Maintenance: **Date of last exam**

_____ Yes _____ No Have you had a treadmill test? _____

_____ Yes _____ No Have you had your stools checked for blood? _____

Females only:

_____ Yes _____ No Have you had a mammogram? _____

_____ Yes _____ No Have you had a PAP test? _____

_____ Yes _____ No Do you perform routine breast self-exams?

Males only:

_____ Yes _____ No Have you had a prostate exam or blood test? _____

_____ Yes _____ No Do you examine your testicles regularly?

Vaccinations: (Please check if you have had)

_____ Tetanus _____ Rubella _____ PnuemoVax _____ Hepatitis

_____ Yes _____ No Have you ever had a blood transfusion?

_____ Yes _____ No Do you have a living will or other advanced directive?

Family History:

Do you know of any blood relative who has had: (Circle and give relationship)

Asthma	_____	Heart Disease	_____
Bleeding Tendency	_____	High Blood Pressure	_____
Cancer	_____	Kidney Disease	_____
Colitis	_____	Leukemia	_____
Colon Polyps	_____	Mental Illness	_____
Diabetes	_____	Migraine	_____
Epilepsy	_____	Stroke	_____
Goiter	_____	Tuberculosis	_____

	Age	Alive?	Cause of Death
Father			
Mother			
Siblings			

(Please turn page)

Review of Systems

HEENT

Glaucoma	_____ Yes	_____ No
Cataracts	_____ Yes	_____ No
Dentures	_____ Yes	_____ No
Sinus problems	_____ Yes	_____ No
TMJ	_____ Yes	_____ No

HEMATOLOGY

Easy bleeding/bruising	_____ Yes	_____ No
Anemia	_____ Yes	_____ No
DVT	_____ Yes	_____ No
PE	_____ Yes	_____ No
Chronic venous stasis disease	_____ Yes	_____ No

ENDOCRINE

Diabetes	_____ Yes	_____ No
Hypothyroidism	_____ Yes	_____ No
Hyperthyroidism	_____ Yes	_____ No

PULMONARY

Asthma	_____ Yes	_____ No
Sleep apnea	_____ Yes	_____ No
COPD	_____ Yes	_____ No
Bronchitis	_____ Yes	_____ No

CARDIOVASCULAR

Hypertension	_____ Yes	_____ No
Dyslipidemia	_____ Yes	_____ No
Chest pain	_____ Yes	_____ No
History of MI	_____ Yes	_____ No
History of CHF	_____ Yes	_____ No
CABG or stents	_____ Yes	_____ No

GASTROINTESTINAL

GERD	_____ Yes	_____ No
Ulcers	_____ Yes	_____ No
Inflammatory bowel disease	_____ Yes	_____ No
Irritable bowel syndrome	_____ Yes	_____ No
Constipation	_____ Yes	_____ No
Diarrhea	_____ Yes	_____ No
Blood per rectum	_____ Yes	_____ No

HEPATIC

Fatty Liver	_____ Yes	_____ No
Cirrhosis	_____ Yes	_____ No
Hepatitis	_____ Yes	_____ No

GENITOURINARY

Prostate problems	_____ Yes	_____ No
Hesitancy	_____ Yes	_____ No
Dysuria	_____ Yes	_____ No
Kidney stones	_____ Yes	_____ No
Stress Incontinence	_____ Yes	_____ No
Uterus/ovary problems	_____ Yes	_____ No
Polycystic ovarian disease	_____ Yes	_____ No
Infertility	_____ Yes	_____ No
Kidney disease	_____ Yes	_____ No
Renal Insufficiency/failure	_____ Yes	_____ No

Review of Systems

RHEUMATOLOGIC

Fibromyalgia	_____ Yes	_____ No
Chronic pain syndrome	_____ Yes	_____ No
Lupus	_____ Yes	_____ No
Scleroderma	_____ Yes	_____ No
Rheumatoid arthritis	_____ Yes	_____ No

MUSCULOSKELETAL

Joint pain	_____ Yes	_____ No
Back pain	_____ Yes	_____ No
Degenerative joint disease	_____ Yes	_____ No
Spinal/Disc disease	_____ Yes	_____ No
Gout	_____ Yes	_____ No
Osteopenia/Osteoporosis	_____ Yes	_____ No

NEUROLOGIC

Pseudotumor cerebri	_____ Yes	_____ No
Migraine headaches	_____ Yes	_____ No
CVA/TIA	_____ Yes	_____ No
Seizures	_____ Yes	_____ No

PSYCHOLOGIC

Depression	_____ Yes	_____ No
Anxiety	_____ Yes	_____ No
Bipolar syndrome	_____ Yes	_____ No
Psychosis/Schizophrenia	_____ Yes	_____ No
Hospitalization	_____ Yes	_____ No
Suicide attempt	_____ Yes	_____ No