Family History

Do any blood relatives have any of the following health problems? Who?

❑ Brain aneurysm ___________________
❑ Asthma ___________________
❑ Cancer ___________________
Type ________________________
❑ Spinal Problems ________________________
❑ Diabetes ___________________
❑ Heart Disease ___________________
❑ Hypertension ___________________
❑ Stroke ___________________
❑ Migraine Headaches ___________________
❑ Neurofibromatosis ___________________
❑ Polycystic Kidney Disease _______________
❑ Bleeding Disorder ___________________

Other ____

Personal History

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated

Do you smoke? ❑ Yes ❑ No Quantity _________________/Day _________________ Years

Do you use alcohol? ❑ Yes ❑ No Quantity _________________/Day _________________ Years

Have you abused illegal / prescription drugs? ❑ Yes ❑ No Drug ____________________________ When? _________________

Are you pregnant? ❑ Yes ❑ No Is it possible you could be pregnant? ❑ Yes ❑ No

Height __________ Weight __________ Hand Preference ❑ Right ❑ Left

Have you experienced any of the following in the past year?

Frequent or severe headaches ❑ Yes ❑ No
Fainting or unconscious spells ❑ Yes ❑ No
Dizziness ❑ Yes ❑ No
Blurred vision ❑ Yes ❑ No
Change in vision ❑ Yes ❑ No
Ringing in your ears ❑ Yes ❑ No
Difficulty hearing ❑ Yes ❑ No
Strange persistent odors ❑ Yes ❑ No
Difficulty swallowing ❑ Yes ❑ No
Sinus trouble ❑ Yes ❑ No
Chest pain ❑ Yes ❑ No
Shortness of breath ❑ Yes ❑ No
Palpitations ❑ Yes ❑ No
Wheezing ❑ Yes ❑ No
How many pillows do you sleep on? ______
Night sweats ❑ Yes ❑ No
Frequent cough ❑ Yes ❑ No

Bloody cough ❑ Yes ❑ No
Fever ❑ Yes ❑ No
Swelling of hands,
feet & ankles ❑ Yes ❑ No
Abdominal pain ❑ Yes ❑ No
Nausea or vomiting ❑ Yes ❑ No
Vomited blood ❑ Yes ❑ No
Diarrhea ❑ Yes ❑ No
Bloody stools ❑ Yes ❑ No
Rectal pain ❑ Yes ❑ No
Weight gain ❑ Yes ❑ No
Weight loss ❑ Yes ❑ No
Pain on urinating ❑ Yes ❑ No
Difficulty starting urination ❑ Yes ❑ No
Getting up at night to urinate ❑ Yes ❑ No
How many times? ____________
Loss of bladder control ❑ Yes ❑ No

Joint pain ❑ Yes ❑ No
Fatigue ❑ Yes ❑ No
Brittleness of nails ❑ Yes ❑ No
Dryness of skin ❑ Yes ❑ No
Easy bruising ❑ Yes ❑ No
Inability to stand heat ❑ Yes ❑ No
Inability to stand cold ❑ Yes ❑ No
Excessive thirst ❑ Yes ❑ No
Excessive urination ❑ Yes ❑ No
Skin rash ❑ Yes ❑ No
Hallucinations ❑ Yes ❑ No
Numbness/Tingling ❑ Yes ❑ No
Menstrual irregularity ❑ Yes ❑ No

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my physician or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: ____________________ Patient's Signature: ____

Electronically Signed (if applicable)

Physician's Signature: ____