

Personal History Form

Name: _____ DOB _____ Today's Date _____

CONSTITUTIONAL SYMPTOMS

Good general health lately No Yes
Recent weight change No Yes
Fever No Yes
Fatigue No Yes
Headaches No Yes

EYES

Eyes disease or injury No Yes
Wear glasses/contact lenses No Yes
Blurred or double vision No Yes
Glaucoma No Yes

EARS, NOSE, MOUTH, THROAT

Hearing loss or ringing No Yes
Earaches or drainage No Yes
Chronic sinus problems or rhinitis No Yes
Nose Bleeds No Yes
Bleeding Gums No Yes
Bad breath or bad taste No Yes
Sore throat or voice change No Yes
Swollen glands in neck No Yes

CARDIOVASCULAR

Heart trouble No Yes
Chest pain or angina pectoris No Yes
Palpitation No Yes
Shortness of breath with walking or lying flat No Yes
Swelling of feet, ankles or hands No Yes

RESPIRATORY

Chronic or frequent coughs No Yes
Spitting up blood No Yes
Shortness of breath No Yes
Asthma or wheezing No Yes

GASTROINTESTINAL

Loss of appetite No Yes
Change in bowel movement No Yes
Nausea or vomiting No Yes
Frequent diarrhea No Yes
Painful bowel movement or constipation No Yes
Rectal bleeding or blood in stool No Yes
Abdominal pain or heartburn No Yes
Peptic ulcer (stomach or duodenal) No Yes

GENITOURINARY

Frequent urination No Yes
Burning or painful urination No Yes
Blood in urine No Yes
Change in force of stream when urinating No Yes
Incontinence or dribbling No Yes
Kidney Stones No Yes
Sexual Difficulty No Yes
Male - Testicle pain No Yes
Female - Pain with periods No Yes
Female - Irregular periods No Yes
Female - Vaginal discharge No Yes
Female - # pregnancies _____ # miscarriages _____
Female - Date of last pap smear _____

TUBERCULOSIS

Exposure to TB No Yes
Treatment for positive TB
Skin test or active TB No Yes

MUSCULOSKELETAL

Joint pain No Yes
Joint stiffness or swelling No Yes
Weakness of muscles or joints No Yes
Muscle pain or cramps No Yes
Back pain No Yes
Cold extremities No Yes
Difficulty in walking No Yes

INTEGUMENTARY (SKIN, BREAST)

Rash of itching No Yes
Change in skin color No Yes
Change in hair or nails No Yes
Varicose Veins No Yes
Breast pain No Yes
Breast lump No Yes
Breast discharge No Yes

NEUROLOGICAL

Frequent or recurring headaches No Yes
Light headed or dizzy No Yes
Convulsions or seizures No Yes
Numbness or tingling sensations No Yes
Tremors No Yes
Paralysis No Yes
Stroke No Yes
Head injury No Yes

PSYCHIATRIC

Memory loss or confusion No Yes
Nervousness No Yes
Depression No Yes
Insomnia No Yes

ENDOCRINE

Glandular or hormone problem No Yes
Thyroid disease No Yes
Diabetes No Yes
Excessive thirst or urination No Yes
Heat or cold intolerance No Yes
Skin becoming dryer No Yes
Change in hat or glove size No Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts No Yes
Bleeding bruising tendency No Yes
Anemia No Yes
Phlebitis No Yes
Past transfusion No Yes
Enlarged glands No Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics No Yes
Morphine, Demerol, or other narcotics No Yes
Novocaine or other anesthetics No Yes
Aspirin or other pain remedies No Yes
Tetanus antitoxin or other serums No Yes
Iodine, Methiolate or other antiseptic No Yes

Other drugs/medications: _____

Known food allergies: _____
