

# PATIENT'S PERSONAL HISTORY

Patient No. \_\_\_\_\_

Date \_\_\_\_\_

**Confidential Record:** Information contained here will not be released except when you have authorized us to do so.

Last Name	First	Middle	Birth Date	Birth Place
Address			City	State
			Zip	Home Phone
			Business Phone	
Occupation	Medicare No.	Medicaid No.	Sex	Marital Status
Insurance Company			Insurance No.	Religion
			M	F

Person to Notify \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of Last Physical Examination \_\_\_\_\_ Doctor \_\_\_\_\_

Family or Referring Physician \_\_\_\_\_ Address \_\_\_\_\_

FAMILY HISTORY			If Living		If Deceased	
	Sex	Age	Health	Age at Death	Cause	
Father						
Mother						
Brothers/Sisters* (Circle Sex)						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
Husband/Wife						
Sons/Daughters* (Circle Sex)						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				

\*Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter.

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

Stroke _____	Epilepsy _____	Heart Attack _____	Nervous breakdown _____
Cancer _____	Suicide _____	Stomach ulcers _____	Rheumatic heart _____
High blood Pressure _____	Migraine _____	Kidney disease _____	Insanity _____
Tuberculosis _____	Asthma _____	Goiter _____	Congenital heart _____
Diabetes _____	Hay fever _____	Arthritis _____	
Leukemia _____	Bleeding tendency _____	Colitis _____	

**PERSONAL HABITS: (Circle)**

Yes No Do you regularly smoke? Cigarettes  Pipe  Cigars  For how many years? \_\_\_\_\_

Yes No Do you usually drink over 6 cups of coffee per day?

Yes No Do you regularly drink alcohol? 1 oz. per day  2 oz. per day  4 oz. per day  over 6 oz. ;  
BEER: 1 bottle per day  2 bottles per day  over 4 bottles per day .

Yes No Do you have difficulty in falling asleep?

Yes No Do you awaken early in the morning without apparent cause?