DEDICATED CARE CENTER

PATIENT PERSONAL HISTORY FORM

Please take time to update the following information for our files. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs.

NAME	BIRTH DATE	DATE

CHIEF COMPLAINTS: *(Please list current symptoms)*

1.	3.
2.	4.

PAST MEDICAL HISTORY: *Hospitalizations and Surgeries*

Reason/Diagnosis/Procedure	Date	Reason/Diagnosis/Procedure	Date

MEDICAL ILLNESSES OR CONDITIONS: *(Conditions you now have or have had in the past.)*

Condition	Onset Date	Condition	Onset Date	Condition	Onset Date
☐ Migraine headaches		☐ Stomach or duodenal ulcer		☐ Goiter	
☐ Seizures or convulsions		☐ Hepatitis		☐ Gonorrhea	
☐ Stroke		☐ Cirrhosis		☐ Syphilis or VD	
☐ Polio		☐ Gall stones		☐ HIV infection	
☐ Glaucoma		☐ Colon or bowel trouble		☐ Herpes infection	
☐ Cataracts		☐ Dysentery or serious diarrhea		☐ Chicken pox	
☐ Blindness		☐ Rectal trouble		☐ Mumps	
☐ Recurrent ear infections		☐ Hemorrhoids		☐ Measles	
☐ Deafness		☐ Recurrent urinary infections		☐ Recurrent boils	
☐ Hay fever, allergic nose		☐ Kidney stones		☐ Skin problems	
☐ Recurrent sinusitis		☐ Other kidney disease		☐ Serious depression	
☐ Asthma		☐ Arthritis		☐ Serious emotional problems	
☐ Chronic bronchitis		☐ Gout		☐ Nervous breakdown	
☐ Emphysema		☐ Broken bones		☐ Other _____	
☐ Tuberculosis		☐ Varicose veins		☐ Other _____	
☐ Heart murmur		☐ Phlebitis or blood clots		*Women*	
☐ Heart attack		☐ Bleeding problems		☐ Menstrual difficulties	
☐ Angina		☐ Anemia		☐ Abnormal PAP	
☐ Enlarged heart		☐ Cancer (Type:_____)		☐ Ovarian cyst(s)	
☐ Rheumatic fever		☐ Diabetes		☐ Breast lump(s)	
☐ High blood pressure		☐ Overactive thyroid		*Men*	
☐ Hiatal hernia / chronic heartburn		☐ Underactive thyroid		☐ Prostate trouble	

CURRENT MEDICATIONS: *(Include non-prescription products)*		**ALLERGIES:** *(Include drugs, foods, chemicals, insects, etc.)*	
Drug Name	Dose	Item	Type of Reaction

IMMUNIZATIONS & PREVENTIVE SERVICES: *(Check all that apply and provide date you last received each.)*

☐ MMR	_____	☐ TB skin test	_____	☐ PAP smear	_____
☐ Tetanus	_____	☐ Hearing test	_____	☐ Mammogram	_____
☐ Pneumonia vaccine	_____	☐ Eye exam	_____	☐ Bone density test	_____
☐ Hepatitis B vaccine	_____	☐ Sigmoid or colon exam	_____	☐ PSA	_____

FAMILY HISTORY: *Please complete the following information on your relatives.*

	Living	Dead	Age	Chronic Condition(s)/Cause of Death
Father				
Mother				
Brothers (No._____) & Sisters (No._____)				
Spouse				
Children (No._____)				

Please check all conditions identified in your relatives and note which relatives are affected:

Condition	Relation	Condition	Relation	Condition	Relation
☐ Migraine headaches	_____	☐ High blood pressure	_____	☐ Bleeding problems	_____
☐ Seizures or convulsions	_____	☐ Stomach or duodenal ulcer	_____	☐ Anemia	_____
☐ Stroke	_____	☐ Liver disease	_____	☐ Sickle cell disease	_____
☐ Glaucoma	_____	☐ Gall stones	_____	☐ Cancer, including leukemia	_____
☐ Allergies	_____	☐ Colon or bowel trouble	_____	☐ Diabetes	_____
☐ Asthma	_____	☐ Kidney stones	_____	☐ Thyroid problems	_____
☐ Emphysema	_____	☐ Other kidney disease	_____	☐ Mental illness	_____
☐ Tuberculosis	_____	☐ Arthritis	_____	☐ Suicide	_____
☐ Heart trouble	_____	☐ Gout	_____	☐ Birth defects	_____

SOCIAL/PERSONAL HISTORY: *Please complete the following information about yourself.*

Current occupation: _____

Education completed:

☐ Grade: _____ ☐ High School ☐ College: _____ years, degree/major_____ ☐ Post-graduate:_____

Marital status: ☐ Single ☐ Married (Date: _____) ☐ Separated (Date: _____) ☐ Divorce (Date: _____)
☐ Widowed (Date: _____)

Married _____ time(s): #1:_____ yrs, _____ children #2:_____ yrs, _____ children #3:_____ yrs, _____ children

Personal habits: *(check all that apply)*

☐ Currently use tobacco: Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless tobacco Amount /day:_____ Years:_____

☐ Former smoker: Amount /day:_____ Years:_____ Quit Date:_____

☐ Exposed to second-hand smoke

☐ Consume alcohol: Type:_____ Amount/day:_____

☐ Use recreational drugs: Type:_____ Frequency:_____

☐ Consume caffeine: Beverage:_____ Amount/day:_____

☐ Exercise regularly: Type:_____ Frequency/week:_____

☐ Wear my seatbelt: Frequency (%):_____

Sexual history: ☐ Multiple sex partners ☐ Prefer opposite sex ☐ Prefer same-sex relationships

Name: _____ Birthdate: _____ Date: _____

REVIEW OF SYSTEMS: *(Please check any item which describes recent or ongoing symptoms)*

General: ☐ *None apply*

☐ Significant weight loss ☐ Loss of feeling of well-being ☐ Fatigue or loss of energy ☐ Difficulty sleeping

Comment: _____

Eyes: ☐ *None apply*

☐ Blurred vision ☐ Double vision ☐ Spots in front of your eyes ☐ Eye pain/irritation ☐ Need for corrective lenses

Comment: _____

Ear-Nose-Throat: ☐ *None apply*

☐ Chronic headaches ☐ Hearing loss ☐ Ringing in ears ☐ Dizziness
☐ Chronic nasal congestion ☐ Recurring sinus infections ☐ Nose bleeds ☐ Nasal obstruction
☐ Bleeding gums ☐ Sore throat ☐ Toothache
☐ Breath odor ☐ Hoarseness

Comment: _____

Respiratory: ☐ *None apply*

☐ Shortness of breath ☐ Cough ☐ Chest congestion ☐ Wheezing
☐ Coughing up blood ☐ Choking ☐ Noisy breathing
☐ History of pneumonia ☐ History of Tuberculosis (TB)

Comment: _____

Cardiovascular: ☐ *None apply*

☐ Chest pain ☐ Heart fluttering/racing ☐ Heart murmur ☐ Decreased exercise tolerance
☐ Awakening due to shortness of breath ☐ Difficulty breathing when lying down ☐ Leg swelling
☐ Pain in buttocks or legs with exercise ☐ Sensitivity of hands/feet to temperature changes

Comment: _____

Breast: ☐ *None apply*

☐ Breast lump ☐ Breast pain ☐ Nipple discharge

Comment: _____

Gastrointestinal: ☐ *None apply*

☐ Stomach pains ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation
☐ Frequent heartburn ☐ Indigestion ☐ Belching/sour taste ☐ Difficulty swallowing ☐ Bloating
☐ History of hepatitis ☐ History of yellow jaundice

Rectal:

☐ Rectal bleeding ☐ Rectal pain or irritation ☐ Swelling or hemorrhoids

Comment: _____

Genitourinary (Men): ☐ *None apply*

☐ Frequent urination (☐ often at night) ☐ Frequent urge to pee ☐ Pain on urination ☐ Bloody urine ☐ Discharge from penis
☐ Trouble starting urination ☐ Interruption of urine stream ☐ Dribbling ☐ Loss of bladder control
☐ Pain or swelling of penis ☐ Pain or swelling of scrotal sac ☐ Pain or swelling in groin
☐ Decline in sexual desire ☐ Difficulty having erections or reaching climax

Comment: _____

Genitourinary (Women): ☐ *None apply*

☐ Frequent urination (☐ often at night) ☐ Frequent urge to pee ☐ Pain on urination ☐ Bloody urine ☐ Frequent urinary infections
☐ Pressure in vagina ☐ Vaginal wall weakness/protrusion ☐ Frequent loss of urine
☐ Vaginal discharge ☐ Vaginal irritation ☐ Vaginal dryness ☐ Vaginal redness ☐ Vaginal pain
☐ Painful intercourse ☐ Decline in sexual desire ☐ Difficulty in sexual response
☐ Hot flashes ☐ Change in periods (menstrual flow, frequency) ☐ Mother took DES while pregnant with me
☐ Painful periods ☐ Troublesome symptoms before/during periods ☐ Other pelvic pain

Please indicate:

Number of pregnancies_____ Number of deliveries_____ Number of miscarriages/abortions_____

Age at onset of periods_____ Periods occur every _____ days and last _____ days Onset of last period_____

Comment: _____

Lymphatic/Hematologic: ☐ *None apply*

☐ Unusual lymph node swelling (in neck, arm pit, or groin) ☐ Painful lymph nodes
☐ History of anemia ☐ Blood clots ☐ Bruise easily ☐ Unusual bleeding

Comment: _____

Musculoskeletal: ☐ *None apply*

☐ Limb or joint pains ☐ Limb or joint deformity ☐ Limb or joint swelling/stiffness/redness
☐ Muscle weakness ☐ Loss of muscle bulk ☐ Muscle spasms or twitching
☐ Recurring back/neck pain ☐ Back/neck injury

Comment: _____

Neurologic: ☐ *None apply*

☐ Seizures ☐ Tremors/shakiness ☐ Unusual clumsiness ☐ Limb weakness ☐ Numbness/tingling ☐ Stroke
☐ History of significant head injury ☐ Altered consciousness or black-outs

Comment: _____

Psychologic: ☐ *None apply*

☐ Lapses in memory ☐ Periods of confusion/disorientation ☐ Difficulty concentrating
☐ Troublesome depression ☐ Worry about things ☐ Mood swings ☐ History of mental illness
☐ Unusual stress ☐ History of physical or mental abuse

Comment: _____

Skin: ☐ *None apply*

☐ Itching ☐ Rash ☐ Unusual dryness ☐ Changes in hair ☐ Changes in pigmentation

Comment: _____

Endocrine: ☐ *None apply*

Unexpected changes in : ☐ Tolerance to heat ☐ Tolerance to cold ☐ Unusual thirst

Comment: _____

Allergy/Immunologic: ☐ *None apply*

☐ Seasonal allergies ☐ Sensitivity to specific items: _____
☐ Frequent or unusual infections

Comment: _____