PATIENT'S PERSONAL HISTORY INFORMATION SHEET DATE _____

NAME: _____ SEX: ☐ MALE / ☐ FEMALE

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____
(STREET) (APT. NO.)

_____
(CITY) (STATE) (ZIP CODE)

PHONE NUMBER: ( ) _____ ( ) _____ ( ) _____
(HOME) (WORK) (MOBILE)

Email address: _____

Preferred method of communication: ☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Other: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

RELIGION: _____ (May leave blank if none, or you wish not to answer)

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

WHERE YOU REFERRED BY ANOTHER PHYSICIAN OR PROVIDER? ☐ YES / ☐ NO

IF YES, PLEASE LIST HIS/HER FULL NAME, ADDRESS, AND PHONE NUMBER: _____

_____

SPOUSE / SIGNIFICANT OTHER: _____

PHONE NUMBER: ( ) _____ ( ) _____ ( ) _____
(HOME) (WORK) (MOBILE)

EMERGENCY CONTACT (If different from above): _____

PHONE NUMBER: ( ) _____ ( ) _____ ( ) _____
(HOME) (WORK) (MOBILE)

Please note that it is very important that we know your *preferred* method of communication. Our office will use your *preferred* method to remind you of your upcoming appointment. We will try your *preferred* method of communication first when calling about urgent matters, and will use your other contact information if we do not find your *preferred* method to be successful.

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INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

ADDRESS: _____ PHONE: _____

POLICY ID #: _____ GROUP #: _____ EFFECTIVE DATE: _____

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

RELATION TO PATIENT: _____ BIRTH DATE: _____ SOC. SEC. #: _____

GROUP / EMPLOYER NAME: _____

SECONDARY INSURANCE CARRIER: _____

ADDRESS: _____ PHONE: _____

POLICY ID #: _____ GROUP #: _____ EFFECTIVE DATE: _____

INSURANCE SUBSCRIBER NAME (if other than patient): _____

RELATION TO PATIENT: _____ BIRTH DATE: _____ SOC. SEC. #: _____

GROUP / EMPLOYER NAME: _____

Even though we are not participating in any insurance plans, we may need your insurance information when prescribing or refilling medications. We may need this information in order to seek special authorization for your medications. We will often need your insurance plan information when ordering laboratory studies, radiology tests, or other procedures.

We will ask for your insurance information at the time of each visit. It is your responsibility to notify us of any changes in your insurance plan(s).

Since we are fee-for-service only, you should not see any charges from our office showing up on your insurance record. If you should see a charge, please notify our office immediately.

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FAMILY HISTORY

Family Member	Sex		If Living		If Deceased	
			Age	Health	Age at death	Cause(s)
Father	M					
Mother		F				
Brothers / Sisters (circle sex)						
	M	F				
	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				

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

Diabetes	_____	Arthritis	_____	Kidney stones	_____
Heart attack < 50 years	_____	Bleeding tendency	_____	Kidney failure	_____
Stroke	_____	Asthma	_____	Migraines	_____
Cancer	_____	Colitis	_____	Seizures	_____
High blood pressure	_____	Stomach ulcers	_____	Mental problems	_____
Goiter (thyroid)	_____	Obesity	_____	Tuberculosis	_____

MEDICATIONS: Please list the medications you take.

Name	Dose	Times per day	Name	Dose	Times per day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ALLERGIES: Please list any medication to which you are allergic.

Name	Reaction	Name	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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OTHER MEDICAL ILLNESSES: Please list other medical problems or illnesses you have or had.

_____
_____
_____
_____
_____
_____
_____
_____

PREVIOUS OPERATIONS: Please list the names and year of any operations you have had.

_____
_____
_____
_____

INJURIES OR ACCIDENTS: Please list any serious injuries or accidents you have had.

_____
_____
_____

PERSONAL HABITS: (Circle)

Yes **No** Do you smoke? ☐ Cigarettes ☐ Cigars ☐ Pipe If so, how many years? _____

Yes **No** Did you smoke previously? If so, when did you quit? _____

Yes **No** Do you drink alcohol? ☐ Liquor ☐ Wine ☐ Beer

If so, how much? _____ Have you ever been arrested for DUI? _____

Yes **No** Do you usually drink over 4 cups of coffee per day?

Yes **No** Do you usually drink over 4 glasses of a caffeinated beverage per day?

ADDITIONAL QUESTIONS:

Yes	**No**	Do you urinate too frequently?	**Yes**	**No**	Do you have excessive thirst?
Yes	**No**	Do you experience frequent fevers?	**Yes**	**No**	Are you easily fatigued?
Yes	**No**	Do you experience frequent chills?	**Yes**	**No**	Are you easily exhausted?
Yes	**No**	Do you experience hot flashes?	**Yes**	**No**	Do you easily feel too cold?
Yes	**No**	Do you have generalized weakness?	**Yes**	**No**	Do you easily feel too hot?
Yes	**No**	Have you noticed skin changes?	**Yes**	**No**	Have you noticed changes in hair?
Yes	**No**	Do you have recent weight loss?	**Yes**	**No**	Do you have recent weight gain?
Yes	**No**	Do you sweat a lot overnight?	**Yes**	**No**	Do you sweat too much?
Yes	**No**	Do you notice bulging of your eyes?	**Yes**	**No**	Do you have any eye pain?
Yes	**No**	Do you have eyesight problems?	**Yes**	**No**	Do your eyes itch?
Yes	**No**	Do you have dry eyes?	**Yes**	**No**	Do you experience double vision?
Yes	**No**	Do you have any loss of hearing?	**Yes**	**No**	Do you have ear aches?
Yes	**No**	Do you have a sore throat?	**Yes**	**No**	Do you have hoarseness?
Yes	**No**	Do you have a swollen tongue?	**Yes**	**No**	Do you have postnasal drip?
Yes	**No**	Do you snore loudly?	**Yes**	**No**	Do you have a goiter?

Yes **No** Are you aware if you had any radiation exposure or treatments to your head or neck in the past?

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Yes	**No**	Do you experience chest pain?	**Yes**	**No**	Have you ever fainted or passed out?
Yes	**No**	Do you feel racing of your heart?	**Yes**	**No**	Do you feel lightheaded or dizzy?
Yes	**No**	Do you have an abnormal heart rate?	**Yes**	**No**	Do you have any heart murmurs?
Yes	**No**	Do you get leg pains when walking?	**Yes**	**No**	Do you have swelling of your legs?

Yes	**No**	Do you have shortness of breath?	**Yes**	**No**	Do you have a chronic cough?
Yes	**No**	Do you have asthma or wheezing?	**Yes**	**No**	Do you easily get short of breath?
Yes	**No**	Do you need more than 1 pillow to sleep?	**Yes**	**No**	Do you awaken short of breath?

Yes	**No**	Do you have abdominal pain?	**Yes**	**No**	Are you troubled by constipation?
Yes	**No**	Do you experience frequent vomiting?	**Yes**	**No**	Do you have frequent diarrhea?
Yes	**No**	Do you experience frequent nausea?	**Yes**	**No**	Do you experience heartburn?
Yes	**No**	Do you have a loss of appetite?	**Yes**	**No**	Do you have dark or black stools?
Yes	**No**	Do you have an excessive appetite?	**Yes**	**No**	Do you notice blood in your stool?
Yes	**No**	Do you experience abdominal cramps?	**Yes**	**No**	Have you ever had jaundice?

Yes	**No**	Do you have burning with urination?	**Yes**	**No**	Do you feel you might lose your urine?
Yes	**No**	Have you ever had blood in your urine?	**Yes**	**No**	Do you have trouble holding urine?
Yes	**No**	Do you awaken overnight to urinate?	**Yes**	**No**	Do you have darkly colored urine?
Yes	**No**	Are you prone to urinary tract infections?	**Yes**	**No**	Have you ever passed a kidney stone?

Yes	**No**	Do you have joint pain?	**Yes**	**No**	Do you have joint swelling?
Yes	**No**	Do you have joint stiffness?	**Yes**	**No**	Do you have muscle aches?
Yes	**No**	Have you been tested for osteoporosis?	**Yes**	**No**	Have you had spine or hip fractures?

Yes	**No**	Do you have any skin lesions?	**Yes**	**No**	Have you noticed a change in a mole?
Yes	**No**	Do you experience skin rashes?	**Yes**	**No**	Do you experience itchy skin?
Yes	**No**	Have you lost any skin pigment?	**Yes**	**No**	Do you have dry skin?
Yes	**No**	Do you bleed or bruise easily?	**Yes**	**No**	Is there a history of blood clots?

Yes	**No**	Do you experience confusion?	**Yes**	**No**	Do you notice any tremors?
Yes	**No**	Do you experience seizures?	**Yes**	**No**	Do you have difficulty walking?
Yes	**No**	Do you notice any numbness or tingling of your hands or feet? (circle which one or both)			

Yes	**No**	Do you suffer with anxiety?	**Yes**	**No**	Have you used illegal drugs?
Yes	**No**	Do you suffer with depression?	**Yes**	**No**	Do you have any sleep disturbance?

QUESTIONS TO BE ANSWERED BY WOMEN ONLY:

Yes	**No**	Do you have pelvic pain?	**Yes**	**No**	Do you bleed between your periods?
Yes	**No**	Is there any vaginal discharge?	**Yes**	**No**	Are you troubled by hot flashes?
Yes	**No**	Is there a history of infertility?	**Yes**	**No**	Are your periods irregular?
Yes	**No**	Are you up to date with gyne follow-up?	**Yes**	**No**	Do you have any breast lumps?
Yes	**No**	Are you currently taking birth control pills?			If so, how long? _____
Yes	**No**	Are you currently taking estrogen replacement pills?			If so, how long? _____
Yes	**No**	Other than with breast-feeding, have you ever experienced any breast discharge?			

Number of pregnancies	_____	**Yes**	**No**	Any childbirths weighing more than 9 pounds
Number of children born alive	_____	**Yes**	**No**	Any history of gestational diabetes
Number of miscarriages	_____	**Yes**	**No**	Any cesarean sections
Number of stillbirths	_____	**Yes**	**No**	Any premature childbirths
Number of terminations	_____	**Yes**	**No**	Other pregnancy complications

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QUESTIONS TO BE ANSWERED BY MEN ONLY:

Yes **No** Is there a history of infertility?

Yes **No** Do you have prostate trouble?

Yes **No** Do you have difficulty maintaining erections?
If so, how long has this been a concern? _____

Yes **No** Have you noticed any change in body hair or need for shaving?

Yes **No** Have you had any treatments or operations involving your genitals (private parts)?

Yes **No** Have you ever abused testosterone?

Yes **No** Do you have testicular pain?

Describe your present medical symptoms or reason for this office visit:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have any medical problems or concerns not addressed in this questionnaire?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

List any other provider (besides the referring provider) who should receive a copy of this evaluation.

Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____