

# PERSONAL HISTORY QUESTIONNAIRE

Date \_\_\_\_\_

*This information is confidential and will not be released without your authorization.*

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle

Ht \_\_\_\_\_ Wt \_\_\_\_\_ Gender: M F Marital Status (please circle): Single Married Widowed Divorced

Date of last physical exam \_\_\_\_\_ Doctor \_\_\_\_\_ Referring Doctor \_\_\_\_\_

Purpose of TODAY'S consultation \_\_\_\_\_

## PAST MEDICAL HISTORY: (If yes, give date of occurrence.)

AIDS or HIV N Y \_\_\_\_\_ Bleeding tendencies N Y \_\_\_\_\_ Asthma N Y \_\_\_\_\_  
Thyroid N Y \_\_\_\_\_ Blood pressure N Y \_\_\_\_\_ Lupus N Y \_\_\_\_\_  
Heart N Y \_\_\_\_\_ Lungs N Y \_\_\_\_\_ Cancer N Y \_\_\_\_\_  
Kidneys N Y \_\_\_\_\_ Nervous problems N Y \_\_\_\_\_ Fibromyalgia N Y \_\_\_\_\_  
Gallbladder N Y \_\_\_\_\_ Bleeding problems N Y \_\_\_\_\_ Arthritis N Y \_\_\_\_\_  
Stomach N Y \_\_\_\_\_ Diabetes N Y \_\_\_\_\_ Scleroderma N Y \_\_\_\_\_  
Hepatitis N Y \_\_\_\_\_ Other serious illnesses you have had \_\_\_\_\_  
Do you regularly smoke? Y N How much per day? \_\_\_\_\_  
Do you regularly drink over 3 cups of coffee per day? Y N  
Do you regularly drink alcohol or beer? Y N How much? \_\_\_\_\_

## MEDICATIONS: Are you presently taking any of the following? (Circle & write name, dose.)

Blood thinners \_\_\_\_\_ Cortisone/steroids \_\_\_\_\_  
Aspirin/Anacin \_\_\_\_\_ Cough/cold medicine \_\_\_\_\_ Seizure Medicine \_\_\_\_\_  
Bufferin \_\_\_\_\_ Thyroid pills \_\_\_\_\_ Blood pressure/heart pills \_\_\_\_\_  
Motrin \_\_\_\_\_ Hormones \_\_\_\_\_ Insulin/diabetic pills \_\_\_\_\_  
Ibuprofen \_\_\_\_\_ Birth control pills \_\_\_\_\_ Antibiotics \_\_\_\_\_ What for? \_\_\_\_\_  
Arthritis medication \_\_\_\_\_  
Other medication not listed \_\_\_\_\_

Do you take herbal supplements? Y N If yes, what are they? \_\_\_\_\_

## DRUG OR SUBSTANCES TO WHICH YOU ARE ALLERGIC \_\_\_\_\_

What happens when you take this? \_\_\_\_\_

## FAMILY HISTORY: Have blood relatives had? (Please circle and give reason.)

High blood pressure \_\_\_\_\_ Arthritis \_\_\_\_\_ Asthma \_\_\_\_\_  
Diabetes \_\_\_\_\_ Stroke \_\_\_\_\_ Goiter \_\_\_\_\_  
Bleeding disorders \_\_\_\_\_ Breast cancer \_\_\_\_\_ Other cancer \_\_\_\_\_

## SERIOUS ILLNESSES OR INJURIES: Please list any serious illnesses or Injuries and dates.

Illness/Injury \_\_\_\_\_ Year \_\_\_\_\_ Illness/Injury \_\_\_\_\_ Year \_\_\_\_\_  
Illness/Injury \_\_\_\_\_ Year \_\_\_\_\_ Illness/Injury \_\_\_\_\_ Year \_\_\_\_\_

## OPERATIONS: Please list operations and year.

Operation \_\_\_\_\_ Year \_\_\_\_\_ Operation \_\_\_\_\_ Year \_\_\_\_\_  
Operation \_\_\_\_\_ Year \_\_\_\_\_ Operation \_\_\_\_\_ Year \_\_\_\_\_

## WOMEN ONLY

Is there a chance you may be pregnant? Y N Regular menses? Y N Date of last menstrual period \_\_\_\_\_  
How many pregnancies? \_\_\_\_\_ How many children? \_\_\_\_\_ Did you breastfeed? Y N How long? \_\_\_\_\_  
Date of last mammogram \_\_\_\_\_  Normal  Abnormal  
Specify abnormality \_\_\_\_\_  
Breast cancer: L R Date \_\_\_\_\_ Mastectomy \_\_\_\_\_ Date \_\_\_\_\_  
Breast biopsy: L R Date \_\_\_\_\_ Oncologist \_\_\_\_\_  
Surgeon for breast biopsy/mastectomy \_\_\_\_\_