

SOUTHERN MEDICAL GROUP, P.A.

Patient No. _____

PATIENT'S PERSONAL HISTORY

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
Employer		Social Security #		Insurance Co.			
Employer's Address		Insurance No.		Sex	Marital Status		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	_____
Cancer	_____	Suicide	_____	Stomach	_____	breakdown	_____
High Blood Pressure	_____	Migraine	_____	ulcers	_____	Rheumatic	_____
Tuberculosis	_____	Asthma	_____	Kidney disease	_____	heart	_____
Diabetes	_____	Hay Fever	_____	Goiter	_____	Insanity	_____
Lukemia	_____	Bleeding tendency	_____	Arthritis	_____	Congenital	_____
				Colitis	_____	heart	_____

PERSONAL HABITS: (Circle)

Yes No Do you regularly smoke? Cigarettes Pipe Cigar For how many years? _____

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

Yes No Do you regularly drink alcohol? 1oz. 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 falling asleep?

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

Yes No Have you ever had a blood transfusion?

Yes No Have you recently traveled extensively?

MEDICATIONS:

Are you presently taking any of the following medications?*(Circle)*

Yes	No	Aspirin, bufferin, anacin	Yes	No	Tranquilizers
Yes	No	Blood pressure pills	Yes	No	Weight reducing pills
Yes	No	Cortisone	Yes	No	Blood thinning pills
Yes	No	Cough medicine	Yes	No	Dilantin
Yes	No	Digitalis	Yes	No	Shots
Yes	No	Hormones	Yes	No	Water pills
Yes	No	Insulin or diabetic pills	Yes	No	Antibiotics
Yes	No	Iron or poor blood medications	Yes	No	Barbiturates
Yes	No	Laxatives	Yes	No	Birth control pills
Yes	No	Sleeping pills	Yes	No	Phenobarbital
Yes	No	Thyroid medicine	Yes	No	Other drugs not listed

Write in the names and years of any operations which you have had:

Name any drugs to which you are allergic and describe the reactions and the symptoms you had:

Write in the names of any diseases you have had which required hospitalization:

Serious illnesses which you have had: (not requiring hospitalization)

Serious injuries or accidents:

Yes No Have you ever had a mammogram? When? _____
 Yes No Are you still having regular monthly menstrual periods? _____
 Yes No Have you ever had bleeding between your periods? When? _____
 Yes No Do you have very heavy bleeding with your periods? When? _____
 Yes No Do you ever feel bloated and irritable before your period? _____
 Yes No Are you now on or have you ever taken the birth control pill? When? _____
 Yes No Have you ever had a miscarriage? When? _____
 Yes No Have you ever had a discharge from the nipple of your breast? When? _____
 Yes No Do you regularly have cancer test of the cervix? Date of last test _____
 Yes No Are you sexually active? _____

How many children born alive? _____ How many miscarriages? _____
 How many stillbirths? _____ How many cesarean operations? _____
 How many premature births? _____ Any complications of pregnancy? _____
 Date of last menstrual period? _____

To be answered by men and women: (Circle)

Yes No Do you frequently have severe headaches? (If yes, answer the following):
 Yes No Do they cause visual trouble?
 Yes No Do they occur on one side of the head?
 Yes No Do they awaken you at night from sleep?
 Yes No Do they feel like a tight hat band?
 Yes No Do they hurt most in the back of the head and neck?
 Yes No Does aspirin relieve them?
 Yes No Have you ever had a flu shot?
 Yes No Have you ever had a pneumonia shot?

Yes No Have you ever fainted? Yes No Have you ever had a convulsion?
 Yes No Spells of dizziness? Yes No Double vision?
 Yes No Spells of weakness of an arm or leg? Yes No Pains in ear?
 Yes No Ringing in the ears? Yes No Nosebleeds?

Yes No Do you have bleeding gums? Yes No Do you frequently have a sore tongue?
 Yes No Do you frequently have trouble swallowing? Yes No Do you frequently have nausea and vomiting?
 Yes No Do you frequently have hoarseness?

Have you ever had shortness of breath?: (Circle)

Yes No Doing your usual work? Yes No Which causes you to cough?
 Yes No Climbing a flight of stairs? Yes No Accompanied by wheezing?
 Yes No Which awakens you at night? Yes No Have you ever coughed blood?
 Yes No Do you have a chronic cough? Yes No Do you cough up much sputum?

Have you ever had chest pain or tightness in the chest which begins: (Circle)

Yes No When exerting yourself? Yes No Radiates down the arm?
 Yes No When walking against a wind? Yes No Disappears if you rest?
 Yes No When walking up a hill? Yes No Occurs only at rest?
 Yes No After a heavy meal? Yes No When walking fast?
 Yes No When upset or excited? Yes No When walking in cold weather?
 Yes No Palpitations If you have chest pain or tightness please explain _____
 Yes No Do you sleep on more than one pillow? _____

Have you recently had pain the stomach which: (Circle)

Yes No Occurs 1-2 hours after a meal?
 Yes No Is brought on by eating fried foods, gassy foods?
 Yes No Awakens you at night?
 Yes No Is relieved by antacid medication?
 Yes No Is relieved with milk or eating?
 Yes No Occurs while eating or immediately after?
 Yes No Is relieved by a bowel movement?
 Yes No Loss of appetite?

