PATIENT’S PERSONAL HISTORY QUESTIONNAIRE Date\_\_\_\_\_\_\_\_\_\_\_

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

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(Last Name) (First Name) (MI)

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(Date of Birth) (Social Security Number)

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(Referring Physician)

1. Describe briefly your present medical symptoms and/or reason for your visit today.

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2. Describe any treatment you have previously received for these symptoms or condition.

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3. List any medical conditions for which you are currently or have previously received treatment. (IE: hypertension, diabetes, arthritis, asthma, coronary artery disease, etc.)

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4. List any surgical procedures you have had and the dates of the procedures.

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5. List any illnesses for which you required hospitalization(s) and the date(s) you were hospitalized.

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6. List all prescribed and over the counter medications you are currently taking and all the dosages.

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Please provide the name, telephone number, and street address of your pharmacy.

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. List the names of any drugs you are allergic to.

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8. Have you ever received a Pneumonia vaccination? Yes\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_

9. Do you now or have you ever used tobacco products? Yes \_\_\_\_\_ (Cigarettes\_\_\_\_\_ Pipe\_\_\_\_\_ Cigars\_\_\_\_\_) No \_\_\_\_\_

10. If you answered YES to using tobacco products, how many packs per day do you or did you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. For how many years did you or have you used tobacco products? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date you quit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Do you regularly drink alcohol? Yes\_\_\_\_\_ No\_\_\_\_\_ 1 oz per day\_\_\_\_\_ 2 oz per day\_\_\_\_\_ 4 oz per day\_\_\_\_\_ Over 6 oz per day\_\_\_\_\_

 Beer: 1 bottle per day\_\_\_\_\_ 2 bottles per day\_\_\_\_\_ Over 4 bottles per day\_\_\_\_\_

13. How many cups of coffee per day do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Do you have difficulty falling asleep? Yes\_\_\_\_\_ No\_\_\_\_\_

15. Do you awaken early in the morning without apparent cause? Yes\_\_\_\_\_ No\_\_\_\_\_

16. Occupational History- Give job description or job title for present and past jobs.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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17. Have you ever had exposure to products that are known to cause disease, such as coal dust, silica, asbestos products, or chicken houses (bird droppings)? Or have you ever been exposed to tuberculosis? If yes, please explain.

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**18. Please fill out the following information regarding your FAMILY HISTORY.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | If Living | If Deceased |  |
|  | **Sex** |  **Age** | **Health Status** | **Age of Death** | **Cause of Death** |  |
|  |  |  | **Good/Fair/Poor** |  |  |  |
| **Father** |  |  |  |  |  |  |
| **Mother** |  |  |  |  |  |  |
| **Husband/Wife** |  |  |  |  |  |  |
| **Brothers/Sisters** |  |  |  |  |  |  |
|  | **M** | **F** |  |  |  |  |  |
|  | **M** | **F** |  |  |  |  |  |
|  | **M** | **F** |  |  |  |  |  |
|  | **M** | **F** |  |  |  |  |  |
|  | **M** | **F** |  |  |  |  |  |
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| **Sons/Daughters** |  |  |  |  |  |  |
|  | **M** | **F** |  |  |  |  |
|  | **M** | **F** |  |  |  |  |
|  | **M** | **F** |  |  |  |  |
|  | **M** | **F** |  |  |  |  |
|  | **M** | **F** |  |  |  |  |
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**Indicate if your blood relatives have/had any of the following conditions; Please note if maternal or paternal grandparents.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | DISEASE |  | RELATIONSHIP TO YOU |  |
| Yes No | Arthritis/Gout |
| Yes No | Asthma or Hayfever  |  |  |  |  |
| Yes No | Cancer |  |  |  |
| Yes No | Diabetes |  |  |  |  |
| Yes No | Heart Disease |  |  |  |  |
| Yes No | Stroke |  |  |  |
| Yes No | Lung Disease |  |  |  |
| Yes No | High Blood Pressure |  |  |  |
| Yes No | Kidney Disease |  |  |  |
| Yes No | Tuberculosis |  |  |  |