AUTUMN ROAD FAMILY PRACTICE, P.A.

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DRS. SOMERS, CALHOUN, WATSON, ROLLINS, KING
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THERE ARE (9) PAGES TOTAL, PLEASE COMPLETE ALL PAGES.

PATIENT'S PERSONAL HISTORY

Date:

Confidential Record: The information on this form will not be released without your authorization.

Full Name: Birth Date: Age:

Address: Home Phone:

Business Phone:

E-mail Address:

Sex: M F Marital Status: M W D S Occupation:

Previous or Referring Physician:

Address:

Reason for Consulting Physician:

Past History Approximate year or age you had the following:

Alcohol or Other Substance Abuse	Diabetes	Mumps
Allergies (Hay Fever, Hives, Eczema)	Diphtheria	Photosensitivity (Allergy to Sunlight)
Anemia	Eating Disorder	Pneumonia
Asthma	Epilepsy	Psoriasis
Bleeding Tendency	Gallbladder /Gall Stones	Radiation or X-ray Therapy
Blood Transfusion	Heart Attack/Bypass/Pacemaker	Rheumatic Fever
Body Piercing/Tattoos	Hepatitis	Scarlet Fever
Cancer	HIV or known exposure	Sexually Transmitted Disease
Chicken Pox	High Blood Pressure	Sinusitis
Colon Disease Polyps, Diverticulitis	Kidney Disease	Stroke or TIA
Inflammatory Bowel Disease,	Kidney Stones	Typhoid Fever
Congestive Heart Failure	Lung Disease (COPD, Emphysema)	Ulcer (Peptic or Duodenal)
Depression/Anxiety	Valvular Heart Disease	
Other Psychiatric Disorders	Migraine Headaches	

Medical Illness Requiring Hospitalization: (Pneumonia, Kidney Stone, Psychiatric Disorder, Drug Rehabilitation, or Other)

Serious Illness Not Requiring Hospitalization:

NAME

Surgical History (Please give approximate year or age.)

Appendectomy Surgeon:

Arthroscopy/Laparoscopy Surgeon:

Gallbladder Surgery Surgeon:

Hemorrhoidectomy Surgeon:

Hysterectomy Surgeon:

List Other Operations:

Surgeon:

Surgeon:

Surgeon:

Accidents: (Injury, Broken Bones, Auto Accidents, Work Accidents)

Prescription Medicines (Including Hormones, Inhalers, Birth Control) Please list all drugs taken recently and the approximate dates that they were started. If you do not know the name, describe the drug's appearance and reason for the drug (Example: "White heart pill taken twice daily.")

DRUG	REASON	PRESCRIBED BY DR.	DATE

Over the Counter Medicines (Including Vitamins, Herbal Supplements, Diet Aids)

Allergies Are you allergic to: (Circle correct answer)

Penicillin: Yes No Sulfa: Yes No Aspirin: Yes No Novocaine/Lidocaine: Yes No

Iodine, Shellfish, X-Ray Dye: Yes No Other Medicines: Yes No

Describe Reaction:

Other Allergies (Foods, Dyes, Pollens, Plants, Pets, Insects) Yes No Name Them:

NAME

Habits Tobacco: How Much? How Long?

Alcohol: How Much? How Long?

Recreational Drug Use? How Long?

Caffeine: (Coffee, Tea, Colas) How Much Per Day? How Long?

Do you follow a special diet? Yes No If Yes, what type?

Do you exercise regularly? Yes No Describe:

Family History	IF LIVING		IF DECEASED	
	Age	Major Health Problems	Age at Death	Major Health Problems
Father				
Mother				
Brothers				
Or				
Sisters				

Husband / Wife (Please give information for each marriage if more than one)

Sons

Or

Daughters

Have any of your "blood relatives" died before the age of 60? Yes No

If so, explain:

Has anyone in your immediate family ever had:

Bleeding Disease	Yes	No	Heart Disease/Heart Attack/		
Cancer	Yes	No	Heart Surgery/Bypass	Yes	No
Crippling Arthritis	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Osteoporosis	Yes	No
Depression/Anxiety/Other			Stroke	Yes	No
Psychiatric Disorder	Yes	No	Sudden Death	Yes	No
Glaucoma	Yes	No	Tuberculosis	Yes	No
Gout	Yes	No	Other:		

NAME

Social History

Birth Place: Where did you grow up?

Religious Affiliation/Preference:

Education

High School: Year: Where:

College: Year: Where:

Degree:

Foreign Countries visited In the Past Two Years:

Military Service:

Recent Exposure to Insect or Animal Bites:

Have you ever been turned down for life Insurance. military service, or employment because of health problems?

Yes No

Occupation: Please list the types of work you have done and the date you last worked. List any special industrial hazards such as dust, chemicals, etc.

JOB	LOCATION	DATE

Review of Systems

Estimated Weight Maximum Adult Height

	YES	NO	COMMENT
GENERAL			
Chills			
Fever			
Sleeping Difficulties			
Fatigue or Exhaustion Sweats			
Recent Weight Loss or Weight Gain			Duration / pounds
Change in Appetite			If yes, Describe

NAME

SKIN

Change in Body Hair Rash
Wart or Moles Removed — Date
Cancer — Date
Itching or Burning
Bleeds Easily

HEENT

Head: Frequent Headaches — Frequency
Neck Lumps or Swelling

Eyes: Glasses — Fitted — Checked
See Halos Around Lights
See Double
Eyesight Worsening
Glaucoma
Dry Eyes

Ears: Hearing Difficulty — Last Checked
Buzzing or Roaring
Infections

Nose: Bleeding
Sinusitis
Allergies

Mouth: Last Dental Check — Date
Last Tooth Pulled — Date

Throat: Hoarse Voice

RESPIRATORY (LUNGS)

Wheezes, Asthma
Daily Cough
Coughed up Phlegm — When?
Coughed up Blood — When?
Shortness of Breath
Pleurisy (Pain on Breathing)
Number of Pillows Slept on — Number
Night Sweating

GASTROINTESTINAL (STOMACH)

Difficulty Swallowing
Food Intolerance
Indigestion (Heartburn) Treatment
Belching

NAME

Regurgitation of Stomach Acid

Vomited Blood

Constipation — Onset

Treatment

Blood in Stool

Black, Tarry Stools — When

Nausea or Vomiting

Change in Stool Color or Size — Describe

Yellow Jaundice or Hepatitis — When

ENDOSCOPY (Scope of Stomach or Colon): — When

Where

X-RAYS/ULTRASOUND:

Gall Bladder — When

Where

Abdomen — When

Where

Pelvis — When

Where

GENITOURINARY (KIDNEYS)

Get up at night to urinate — Number of Times

Infection of Bladder or Kidney

Burning on Urination

Difficulty Starting Urine/Stopping Urine

Frequent Urination — Number of Times

Brown, Black or Bloody Urine

Testicles: Painful or Lumps

Discharge

Kidney Stones

Last Kidney X-ray — When

WOMEN

Last Menstrual Period — Date

Menstrual Trouble

Age at 1st Menstrual Cycle — Age

Age at 1st Live Birth — Age

Number of Mother/Sisters with Breast Cancer — Number

Any Previous Breast Biopsy? — When

Lumps in Breast

Vaginal Discharge

NAME

Number of Pregnancies		Number
Number of Deliveries		Number
Number of Miscarriages		Number
Birth Weight of Heaviest Child		Weight
Complications of Pregnancy		
Last Pap		Date
Nipple Discharge		
Hot Flashes		
Mood Changes or Irritability		
Cry Easy		
Abnormal Pap Smears		Date
Hormones: Birth Control Pills		Duration
		Date Stopped
Other Hormones		Duration
		Date Stopped
Surgery:	Uterus Removed	Date
	Cervix Removed	Date
	Ovaries Removed	Date

CARDIOVASCULAR HISTORY

Have you ever been told that you had any of the following illnesses?

Heart Disease	
Heart Murmur	
Enlarged Heart	
Heart Attack	
Coronary	
Myocardial Infarction	
Angina	
Rheumatic Heart	
Leaky Heart	
Hole in Your Heart	
Inflamed Heart	
Heart Failure	
Aneurysm	
High Blood Pressure	
High Cholesterol (Fat in Blood)	
Rheumatic Fever	Age
Abnormal ECG (Heart Trace)	When
Shortness of Breath with Exertion	

NAME

Are you bothered by:

- Chest Pain
- Chest Tightness Arm Pain
- Neck Pain
- Leg Cramps While Walking
- Skipped Heart Beats or Palpitations
- Smothering Spells
- Leg or Ankle Swelling

Have you taken any of the following medications in the past year?

- Nitroglycerine (Under Tongue)
- Digitalis
- Fluid or Water Pills
- Medicine for High Blood Pressure
- Anticoagulants (Blood Thinning Pills)
- Other Heart Medications — Name

Heart Test or Procedure

- Last ECG (Electrocardiogram) — When
- Echocardiogram — When

Review of Systems Continued

- Coronary Arteriogram — When
- Other Heart Procedure/Surgery: — Type
  When
- Pacemaker: — When
- Carotid Tests: — When

MUSCULOSKELETAL (Bones & Muscles)

- Arthritis or Swollen Joints
- Bursitis or Tendonitis
- Back or Shoulder Problems
- Painful Feet
- Sciatica

METABOLIC (Glandular)

- Diabetes or Sugar in Urine
- Thyroid Disease (Goiter)
- Tend to be Hot or Cold — Describe
- Radioactive Iodine for Thyroid Treatment

NEUROLOGICAL

- Fainting or Blackouts
- Epilepsy, Convulsions, or Seizures Dizziness

NAME

Numbness

Tending to Tremble or Shake

Lonely or Depressed

Cries Often

Hopeless Outlook

Worries A Lot

Work or Family Problems

Considered Suicide

Considered or Desired Psychiatric Help Weakness

Difficulty Speaking

Depression or Anxiety

Significant Change in Memory

Decline in Mental Ability

Anything not listed above?

Is there anything "special" or "personal" that you need to discuss with the doctor? Yes No

Do you have a "Living Will"? Yes No

Where are your sources of hope, comfort or strength?

What pharmacy do you use:

Name ____

Location ____ Phone _______________________________