PATIENT'S PERSONAL HISTORY Date of Initial Visit _____

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last	First	Middle	Birth Date	Age	Birth Place

Address	City	State	Zip	Home Phone	Business Phone

Occupation	Employer	Marital Status							Religion			
		M	F	S	M	W	D	Separated	A	C	J	P

Health Ins. Co.: _____ Contract No. _____ Subscriber: _____

Supplemental Health Ins. Co.: _____ Contract No. _____ Subscriber: _____

Person to Notify: _____ Relationship: _____

Address: _____ Phone Number: _____

Date of Last Ob. Gyn. Exam: _____ Doctor: _____

Date of Last Complete Physical Exam: _____ Doctor: _____

Family Physician: _____ Address: _____

Referring Physician: _____ Address: _____

I would like a Report of this Consultation Sent to Doctor: _____

What is your chief complaint: _____

Onset at age:

Circle "Yes" or "No"

Yes No Do you frequently have severe headaches?
Yes No Do they occur on one side of the head? Which side? R_____ L_____
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 Do they hurt most in the front of the head, forehead or sinus area?
Yes No Does aspirin relieve them?
Yes No Do you frequently have excess tears in your eyes?
Yes No Do you have frequent ear aches?
Yes No Have you ever had a punctured ear drum or draining ear?
Yes No Do you now have decreased hearing?
Yes No Are you frequently hoarse?
Yes No Do you frequently get sore throats?
Yes No Do you frequently have a stuffy nose?
Yes No Do you frequently have mucus in the back of your throat?
Yes No Have you ever had nasal polyps?
Yes No Do you wake up in the middle of the night short of breath?
Yes No Do you wake up coughing first -- then wheeze?
Yes No Do you wake up wheezing first, -- then cough?
Yes No Do you cough up mucus or phlegm on arising almost every morning?
_____times How many times have you had pneumonia?
Yes No Have you chills or fever with your breathing problems?
Yes No Have you ever had pleurisy?
Yes No Have you ever coughed up blood?

SEASONALITY: Mark the following boxes as follows: No Symptoms = 0 Any Symptoms = + Severe Symptoms = ++

SAMPLE: If you have hayfever (but no asthma, hives, eczema or arthritis) each Fall only, at home and at work and no symptoms in the winter, your answer might look like this:

CONDITION (Circle your symptoms) Asthma	Age Began	Summer	Winter	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Home	Work
Nasal (Congested Nose) (Itchy Eyes) (Sneezing) (Frequent Colds)	11 yrs.	+	0								+	++	+			+	+

CONDITION (Circle your symptoms) Asthma and/or Chronic Cough (wheezing, even if slightly)	Age Began	Summer	Winter	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Home	Work
Nasal (Congested Nose) (Itchy Eyes) (Sneezing) (Frequent Colds)																	
Hives																	
Eczema																	
Arthritis																	

ENT SURGERY:

Tonsils removed _____ Age _____ Ear or nose surgery _____ Age_____

FAMILY HISTORY:	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				
Brothers or Sisters (B) or (S)				
Husband or Wife				
Sons or Daughters (S) or (D)				

Do you know of any other blood relative who has or had: (Circle and give relationship)

Heart attack	_____	Bleeding tendency	_____	Stomach ulcers	_____
Stroke	_____	Migraine	_____	Kidney disease	_____
High blood pressure	_____	Epilepsy	_____	Goiter	_____
Diabetes	_____	Suicide	_____	Colitis	_____
Tuberculosis	_____	Nervous breakdown	_____	Arthritis or gout	_____
Cancer or leukemia	_____	Mental disease	_____		

PERSONAL HABITS:

Yes No Do you regularly smoke? Cigarettes _____ Pipe _____ Cigars _____

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

Yes No Do you regularly drink alcohol? 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 _____

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

Operations	Year	Operations	Year

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

Diseases	Year	Diseases	Year

Serious Injuries or Accidents:	Year

Serious Illnesses which you have had: (not requiring hospitalization)	Year

IMMUNIZATIONS:

	Date				
Tetanus					
Polio, oral			Polio, injection		
Smallpox					
Measles					
Tuberculin (PPD or Tine)					
German Measles					
Mumps					
Flu					

ATOPY:

Parents, grandparents, brothers or sisters who have had any of the following (write in relationship)

Asthma _____ Hayfever _____ Hives _____

Eczema _____ Bee sting allergy _____

ENVIRONMENT:

Type of heat at home: hot air _____ hot water _____ electric _____ woodburning stove _____ space heater _____

Type of heat at work: hot air _____ hot water _____ electric _____ woodburning stove _____ space heater _____

Animals or pets at home: _____ Since when: _____ Where do they sleep: _____

Animals at work: _____ Approx. age of your house _____ City _____ Country _____

Pillows stuffed with (see label) _____ Mattress stuffed with (see label) _____

Type of underpadding of rugs: synthetic _____ animal hair_____

House plants (how many) _____

Hobbies and other activities: Indoors _____ Outdoors _____

AGENTS:

Circle any of the following that you actually have noticed causing you wheezing, coughing, nose running, nose congestion or hives:

dogs	cats	horses	other animals
barn	beer or wine	gardening	basement
hairspray	wool	rain	insect spray
air conditioning	cosmetics	perfumes	after shave lotion
dust	drafts	humidity	after bath or shower
tobacco smoke	strong odors	alcoholic beverages	
fatigue	anything at work	rapid change in temperature	
hot weather	cold weather		

FOOD AND MEDICATION ALLERGIES:

Food to which you have actually had an allergic reaction: _____

Reaction: _____ How long after eating it? _____

Medications that have caused a bad reaction (for example rash, swelling, wheezing) Penicillin ____ reaction _____

Tetanus injection ____ reaction _____ Aspirin _____ reaction _____ Name any other drugs to which you are allergic _____ reaction_____

STINGING INSECT ALLERGY:

Stinging insect reaction: (bee, hornet, wasp) local swelling? _____

Big generalized reaction? (Describe) _____

PREVIOUS ALLERGY TESTING AND TREATMENT:

Have you been skin tested for allergies? _____ When? _____ by Dr. _____

What reacted? _____

Have you ever received injection treatments against allergies? _____ Started: _____

Date of last injection: _____ Whate was in the injection? _____

PREVIOUS STEROID TREATMENT:

Have you ever received cortisone medications (Prednisone, Decadron, Medrol, Kenalog, Aristocort, Steroids) _____ by injection or pill? _____

Date of last dose _____ How long did you take them? _____ What dose _____ Every day _____

Every other day _____ Dose was reduced each day _____

Do you or did you ever have diabetes _____ ulcer _____ tuberculosis _____ high blood pressure _____

OTHER MEDICATIONS, INHALER, NOSE SPRAY AND SMOKING:

What medications (pills, capsules, injections, liquids, drops, ointments, or sprays) have you taken in the past month? Include aspirins, birth control pills, etc. _____

Are you or have you ever been a smoker? _____ How many years? _____ Packs per day? _____ Stopped? _____

Do you use a hand spray (mouth) inhaler? _____

When was the last time you used a nose spray or drops? _____

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

Yes	No	Asprin, Bufferin, Anacin	Yes	No	Laxatives	Yes	No	Shots
Yes	No	Blood pressure pills	Yes	No	Sleeping pills	Yes	No	Water pills
Yes	No	Cough medicine	Yes	No	Thyroid medicine	Yes	No	Antibiotics
Yes	No	Digitalis	Yes	No	Tranquilizers	Yes	No	Barbituates
Yes	No	Hormones	Yes	No	Weight reducing pills	Yes	No	Birth control pills
Yes	No	Insulin or diabetic pills	Yes	No	Blood thinning pills	Yes	No	Phenobarbital
Yes	No	Iron or poor blood medications	Yes	No	Dilantin	Yes	No	Other drugs not listed

WOMEN skip to next section - To be answered by MEN only: Have you ever had: (Circle)

Yes No Loss of sexual activity
Yes No Treatment for genitals (private parts)
Yes No Discharge from penis
Yes No Hernia (rupture)
Yes No Prostate trouble

MEN skip to next section - To be answered by WOMEN only: (Circle)

Yes No Are you still having regular menstrual periods?
Yes No Have you ever had bleeding between your periods?
Yes No Do you have very heavy bleeding with your periods?
Yes No Are you now on or have you ever taken the birth control pill?
Yes No Have you ever had a discharge from the nipple or your breast?
Yes No Do you regularly have the cancer test of the cervix?

How many times have you been pregnant _____
How many children born alive _____
How many miscarriages _____
How many children living today _____
How many stillbirths _____
How many premature births _____
Date of last menstrual period _____
How many cesarean operations _____
Any complication of pregnancy _____
Date of last cancer test of the cervix (PAP smear) _____

To be answered by MEN AND WOMEN: (Circle)

Yes No Have you ever fainted?
Yes No Spells of dizziness?
Yes No Have you ever had a convulsion?
Yes No Have you ever had double vision?
Yes No Do you wear glasses or contacts?
Yes No Do you frequently get ringing in ears?
Yes No Do you frequently have bleeding gums?
Yes No Do you frequently have trouble swallowing?
Yes No Do you frequently have a sore tongue?
Yes No Do you get short of breath walking up one flight of stairs?
Yes No Do you sleep on 2 pillows or more?
Yes No Do you feel skipped heart beats or racing heart not caused by exertion or excitement?
Yes No Do you get chest pain on exertion?
Yes No Do you get chest pain that radiates down the arm?
Yes No Have you ever been told you have a heart murmur?
Yes No Have you ever had heart trouble?
Yes No Have you ever had scarlet fever?
Yes No Have you ever had rheumatic fever?
Yes No Do you get heartburn bending forward to put on your shoes?
Yes No Do you get heatburn lying in bed at night?
Yes No Do you get a bile taste coming up frequently?
Yes No Do fried, fatty or gassy foods cause abdominal pain consistently?
Yes No Has nausea been a frequent or serious problem?
Yes No Has vomiting been a frequent or serious problem?
Yes No Has constipation been a frequent or serious problem?
Yes No Has diarrhea been a frequent or serious problem?
Yes No Has abdominal pain been a frequent or serious problem?
Yes No Have you frequently or recently had mucous in the stool?
Yes No Have you ever had blood in the stool?
Yes No Have you ever had tar-black stools?
Yes No Do you frequently need or use laxatives or enemas?
Yes No Have you ever had jaundice, hepatitis or liver disease?
Yes No Have you ever had a urinary infection? How many? _____
Yes No Have you recently had pain or burning with urination?
Yes No Have you ever had blood in your urine?
Yes No Have you ever had a kidney stone?
Yes No Do you lose your urine when you cough, sneeze or laugh?
Yes No Have you had trouble starting to urinate?
_____times How many times do you get up to urinate after going to bed?
Yes No Have you lost more than 5 pounds in the past year, involuntarily?
Yes No Do you feel yourself flush or blush for no reason?
Yes No Does hot weather bother you more than other people?
Yes No Does cold weather bother you more than other people?
Yes No Have you recently had cramps, pain, stiffness or swelling of your joints, arms, legs, fingers or toes?
Yes No Have you ever had any neck problems?
Yes No Have you ever had any back problems?
Yes No Do your fingers turn white or blue in the cold (more so than other people)?
Yes No Do you have varicose veins?
Yes No Do your ankles swell?
Yes No Did you ever have phlebitis or inflamed leg veins?

Patient Name:_____DOB:_____AAIR #:_____

Please list below any specific questions you would like addressed by the physician at the time of your visit.