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Internal Medicine
Pulmonary Medicine

PATIENT'S PERSONAL HISTORY

Confidential Record: Information contained herein will not be released without your authorization

Last Name *First Name* *Middle Initial* *Age* *Today's Date*

Country of Birth *Religion* *Occupation* *Date of Last Physical Exam*

Reasons for Physical Examination or Problems you wish to discuss:

1. _____ *4.* _____

2. _____ *5.* _____

3. _____ *6.* _____

FAMILY HISTORY		If Living		If Deceased	
		Age	**Health**	**Age at Death**	**Cause**
Father's Name					
Mother's Name					
Brothers/Sisters' Names	(Circle Sex) M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife's Name					
Children's Name(s)	(Circle Sex) M F				
	M F				
	M F				
	M F				
	M F				

FAMILY HISTORY

Check if any *blood relative* has or has had any of the following and enter relationship.

	Yes	No	Relationship
Hypertension	☐	☐	
High Cholesterol	☐	☐	
Heart Attacks	☐	☐	
Heart Murmur	☐	☐	
Stroke	☐	☐	
Bleeding or Blood Clots	☐	☐	
Diabetes	☐	☐	
Thyroid Disease or Nodules	☐	☐	
Dementia	☐	☐	
Asthma	☐	☐	
Emphysema	☐	☐	
Tuberculosis	☐	☐	
Pneumonia	☐	☐	
Sleep Apnea	☐	☐	
Stomach Ulcers	☐	☐	
Colitis	☐	☐	
Arthritis	☐	☐	
Immune Deficiency	☐	☐	
Gout	☐	☐	
Kidney Failure	☐	☐	
Kidney Stones	☐	☐	
Cancer	☐	☐	
Leukemia	☐	☐	
Seizures	☐	☐	
Depression	☐	☐	
Schizophrenia	☐	☐	
Psychiatric Hospitalization	☐	☐	

PAST HISTORY (Personal)

Have you had any of the following illnesses?

	Yes	No		Yes	No
Rheumatic Fever	☐	☐	Diabetes	☐	☐
Angina Pectoris	☐	☐	Cancer	☐	☐
Heart Attack	☐	☐	Kidney Disease	☐	☐
Other Heart Disease	☐	☐	Frequent Kidney or Bladder Infections	☐	☐
Hypertension	☐	☐	Stomach Ulcers	☐	☐
Elevated Cholesterol	☐	☐	Irritable Bowel	☐	☐
Anemia	☐	☐	Colitis	☐	☐
Bleeding or Excess Clots	☐	☐	Gallbladder Disease	☐	☐
Gout	☐	☐	Hepatitis	☐	☐
Seasonal Allergies	☐	☐	Arthritis	☐	☐
Asthma	☐	☐	Migraine Headache	☐	☐
Frequent Lung Infections	☐	☐	Seizures	☐	☐
Tuberculosis	☐	☐	Others (list)	☐	☐
Emphysema	☐	☐			
Sleep Apnea	☐	☐			
Thyroid Disease or Nodules	☐	☐			

Operations: List and indicate approximate year.

Hospitalizations (other than operations)**:** *List reasons and approximate dates.*

Serious Injuries: List and give approximate dates:

Diagnostic X-Rays: List and give approximate dates and results:

Immunizations: Please give dates.

Pneumovax 23 _____ Tetanus/Pertussis _____

Prevnar 13 _____ Last TB Test _____

Shingles Vaccine _____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list medications and the reaction you had to them:

PERSONAL HABITS

1. ☐ Did you ever smoke cigarettes? Yes ☐ No ☐

   ☐ Did you ever smoke a pipe or cigars? Yes ☐ No ☐

   How long have you been smoking? _____ Years

   ☐ Cigarettes ☐ Pipe ☐ Cigars

   Number per day? _____

   ☐ Former smoker: Stopped _____ years ago

2. Check if you regularly drink:

   ☐ Hard liquor ☐ 1-3 oz. per day ☐ Over 3 oz. per day

   ☐ Beer/Wine Amount _____

3. Do you drink coffee? Yes ☐ No ☐ 3 or more cups ☐

4. Do you have difficulty sleeping? Never ☐ Often ☐ Sometimes ☐

5. Have you used recreational drugs? Never ☐ Often ☐ Sometimes ☐

OCCUPATIONAL

	Yes	No
Are you presently unemployed?	☐	☐
Are you dissatisfied with your present type of work?	☐	☐
Does your work involve unusual work, exposure to dust, noise, radioactivity, etc.?	☐	☐
Do you have more than one job?	☐	☐
Do you work more than 60 hours a week?	☐	☐
Do you get along poorly with your fellow employees and/or your supervisors?	☐	☐
Are you unable to perform any work because of disability?	☐	☐
Are you retired?	☐	☐
If retired, have you had difficulty adjusting to retirement?	☐	☐

AIDS RISK ASSESSMENT

Did you ever share needles to shoot drugs into your veins or under your skin?	☐	☐
Have you ever had sex with someone who used needles to shoot drugs?	☐	☐
Have you ever had sex with someone who has AIDS or a positive test for antibody to the AIDS virus?	☐	☐
Have you ever had sex with a man who had sex with other men?	☐	☐
Were you born in or have you lived in a country with a high number of AIDS cases?	☐	☐
Are you a hemophiliac? Is your sex partner a hemophiliac?	☐	☐
Have you had sex for money or drugs? Have you had sex with someone who sells sex for money or drugs?	☐	☐
Did you or your sex partner receive blood between 1977 and 1985?	☐	☐
Have you had sex with multiple partners in the last 12 months?	☐	☐

MARITAL/FAMILY

	Yes	No
Has there been a recent change in your marital status?	☐	☐
Do you have any sexual problems?	☐	☐
Do you have any serious problems with your children?	☐	☐
Is your present home life causing unhappiness?	☐	☐
Does anyone in your family have a serious illness or disability?	☐	☐
Does anyone in your family have a drug or alcohol problem?	☐	☐

SOCIAL HISTORY

Have you recently lived or traveled outside of the U.S.?	☐	☐
Did you complete high school?	☐	☐
Did you attend and/or complete college?	☐	☐
Were you rejected from the Military Service?	☐	☐
Have you ever been rejected for life or health insurance or had to pay an extra premium?	☐	☐
Do you eat less than three meals a day?	☐	☐
Do you have special food customs or restrictions?	☐	☐
Have you ever been treated for a drinking problem?	☐	☐
Do you exercise less than three times a week?	☐	☐
Are you active in political, community, or church activities?	☐	☐
Do you have a hobby or hobbies?	☐	☐

Please identify your hobby or hobbies:

_____

_____

_____

MEDICATIONS

Current Medications. Include drug name, dosage, number of times taken per day. (Include over the counter meds.) Please use other side of this page if necessary.

_____

_____

_____

_____

_____

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_____

Review of Systems:

A. General Yes No

- Do you worry a lot about your health? ☐ ☐
- Do you usually feel tired or worn out? ☐ ☐
- Do you feel depressed a lot of the time? ☐ ☐
- Have you recently noticed that heat or warm weather bothers you? ☐ ☐
- Have you recently been drinking more water or fluids? ☐ ☐
- Has there been any unusual weight gain or loss recently? ☐ ☐

B. Skin

Have you noticed:

- any change in the color of your skin? ☐ ☐
- any skin rashes or itches? ☐ ☐
- unusually dry skin? ☐ ☐
- any growth on your skin that bothers you? ☐ ☐
- any sores or wounds that do not heal? ☐ ☐
- any change in the color or size of warts? ☐ ☐

C. Eyes

Have you had:

- any pain in your eyes? ☐ ☐
- glaucoma? ☐ ☐
- blurry vision? ☐ ☐
- halos around lights? ☐ ☐
- change in vision? ☐ ☐

Date of last exam and Doctor's Name

_____

D. ENT

Do you have:

- any trouble hearing? ☐ ☐
- ringing or buzzing in your ears? ☐ ☐
- earaches or discharge from your ears? ☐ ☐
- a lot of nasal stuffiness? ☐ ☐
- drainage down the back of your throat? ☐ ☐
- frequent or severe nosebleeds? ☐ ☐
- persistent hoarseness? ☐ ☐
- a lump in your throat? ☐ ☐
- a sore tongue or mouth? ☐ ☐
- bleeding gums? ☐ ☐

Date of last dentist visit and Dentist's Name

_____

E. Respiratory

Do you have:

- frequent chest colds? ☐ ☐
- a constant or bothersome cough? ☐ ☐
- sputum or phlegm between colds? ☐ ☐
- blood in your sputum? ☐ ☐
- difficulty breathing? ☐ ☐
- daytime somnolence? ☐ ☐

Have you noticed any wheezing or whistling in your chest? ☐ ☐

Do you:

- stop breathing at night? ☐ ☐
- awake choking? ☐ ☐
- snore? ☐ ☐
- fall asleep while driving? ☐ ☐

F. Cardiovascular Yes No

- Do you have pain, tightness or pressure in the front or back of your chest? ☐ ☐
  - If yes, is it when walking fast, working hard, or when excited? ☐ ☐
- Have you ever been told that your electrocardiogram was abnormal? ☐ ☐
- Do you have swelling of your feet or ankles? ☐ ☐
- Does your heart ever beat fast or irregularly? ☐ ☐
- Do you have cramps in the calf muscles when you walk? ☐ ☐
- Do you ever awaken at night with severe difficulty breathing? ☐ ☐
- Do your fingers or toes ever get cold, become numb, or get very white or bluish? ☐ ☐

G. Gastrointestinal

- Have you recently had any change in your eating habits? ☐ ☐
- Are there any special foods that cause you to have stomach pains, nausea, etc.? ☐ ☐
- Do you tend to burp a lot? ☐ ☐
- Have you recently noted any trouble swallowing? ☐ ☐
- Do you have significant indigestion or heartburn? ☐ ☐
- Do you have frequent nausea and/or vomiting? ☐ ☐
- Have you ever vomited blood? ☐ ☐
- Are you bothered with constipation? ☐ ☐
- Do you have frequent loose stools or diarrhea? ☐ ☐
- Do you pass a lot of gas? ☐ ☐
- Do you have a poor appetite? ☐ ☐
- Do you ever awaken at night with the feeling of fullness underneath your breast bone? ☐ ☐
- Have you ever passed blood from your rectum? ☐ ☐
- Have you ever had black or tarry stools? ☐ ☐
- Have you noticed any recent changes in your bowel movements? ☐ ☐
- Do you take laxatives regularly? ☐ ☐

Date of last colonoscopy and Doctor's name

_____

H. Genitourinary

Do you have:

- any problems with your genitals? ☐ ☐
- burning or pain when you urinate? ☐ ☐
- to pass water frequently? ☐ ☐
- to pass more water than you used to? ☐ ☐
- trouble passing water? ☐ ☐
- to get up at night to urinate? ☐ ☐
- trouble with losing urine when you cough or sneeze? ☐ ☐
- a problem dribbling urine? ☐ ☐
- Have you ever passed blood in your urine? ☐ ☐
- Have you had an operation to prevent pregnancy: (Vasectomy, tubal ligation, etc.?) ☐ ☐
- Men, do you have prostate gland trouble? ☐ ☐
- Men, do you have problems with erections? ☐ ☐

I. Musculoskeletal

- Do you have a problem with back pain? ☐ ☐
- Does back pain interfere with your work or activities? ☐ ☐
- Do you have pain in your legs or feet? ☐ ☐
- Do you have joint pain or stiffness? ☐ ☐
- Do you have trouble walking or using your hip or knee joints? ☐ ☐

J. Central Nervous System

	Yes	No
Do you have frequent or severe headaches?	☐	☐
Do you often have spells of dizziness, faintness or light-headedness?	☐	☐
Have you recently fainted, blacked out or lost consciousness?	☐	☐
Have you ever seen double?	☐	☐
Do you sometimes lose track of what happens around you for a short time?	☐	☐
Do you have trouble remembering recent events?	☐	☐
Do you sometimes lose the ability to speak for a few seconds?	☐	☐
Have you ever had seizures?	☐	☐
Do you have numbness or tingling in your head, arms or legs?	☐	☐
Do you consider yourself a nervous person?	☐	☐
Do you cry a lot for no reason?	☐	☐
Have you ever had an urge to commit suicide?	☐	☐
Do you ever hear voices or see people when no one is around?	☐	☐
Do you ever have a feeling that someone is trying to harm you?	☐	☐

K. Women Only

	Yes	No
Did your menstrual periods start before you were 10?	☐	☐
Did your menstrual periods start after you were 15?	☐	☐
Are your menstrual periods irregular?	☐	☐
Are your periods less frequent than every four weeks?	☐	☐
Are your periods more frequent than every four weeks?	☐	☐
Do you pass clots with your periods?	☐	☐
Do you become bloated or gain weight just before your periods?	☐	☐
Have you passed the menopause or change?	☐	☐
Do you have hot flashes?	☐	☐
Have you had any abortions or miscarriages?	☐	☐
Have you ever used an intrauterine device (IUD)?	☐	☐
Have you used other birth control measures?	☐	☐
Have you had any lumps in your breast?	☐	☐
Have you had any discharge from your nipples?	☐	☐

Date of your last Pap Smear _____

Name of gynecologist _____

Date of last mammogram _____

ADDITIONAL COMMENTS

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