PINNACLE HEALTHCARE SYSTEM

PATIENT PERSONAL HISTORY DATE_____

LAST NAME	FIRST	MIDDLE	BIRTH DATE:	BIRTH PLACE
ADDRESS	CITY	STATE ZIP	PHONE:	WORK PHONE:
OCCUPATION:	INSURANCE:	MALE FEMALE	MARITAL STATUS	RELIGION

IN CASE OF EMERGENCY WHO SHOULD WE NOTIFY?

_____RELATIONSHIP TO YOU_____

ADDRESS_____PHONE_____

DATE OF LAST PHYSICAL EXAM_____DOCTOR_____

PRIMARY OR REFERRING DOCTOR_____ADDRESS_____

FAMILY HISTORY	**SEX**	**AGE**	**IF LIVING: HEALTH**	**Age at Death**	**IF DECEASED: CAUSE**
MOTHER	XXX				
FATHER	YYYY				
M-GRANDMOTHER	XXX				
M-GRANDFATHER	YYY				
P-GRANDMOTHER	XXX				
P-GRANDFATHER	YYY				
SIBLINGS:					
	M/F				
	M/F				
	M /F				
	M/F				
	M/F				

DO YOU HAVE ANY RELATIVE WHO HAS OR HAS HAD ANY OF THE FOLLOWING: (please circle and give relationship to you)

STROKE _____ EPILEPSY_____ HEART ATTACK_____ NERVOUS BREAKDOWN_____

CANCER_____ SUICIDE_____ STOMACH ULCER_____ RHEUMATIC HEART_____

MIGRAINE_____ KIDNEY DISEASE_____ HAY FEVER_____ HIGH BLOOD PRESSURE_____

TUBERCULOSIS_____ ARTHRITIS_____ LEUKEMIA_____ GOITER_____ COLITITS_____

CONGENITAL HEART DISEASE_____ DIABETES_____ INSANITY_____ ASTHMA_____ BLEEDING_____

PERSONAL HISTORY

Yes No Do you regularly smoke? ◊ Cigarettes ◊ Pipe ◊ Cigars _____per day, for _____ years

Yes No Do you drink coffee? How many cups per day? _____

Yes No Do you regularly drink alcohol? ◊ 1oz per day ◊ 2 oz. per day ◊ 4 oz per day ◊ over 6oz per day

BEER ◊ 1 bottle per day ◊ 2 bottles per day ◊ over 4 bottles per day

Yes No Do you have trouble falling asleep?

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

MEDICATIONS: Are you presently taking any of the following medications?

Yes	No	Aspirin, Bufferin, Anacin	Yes	No	Blood pressure pills	Yes	No	Cortisone
Yes	No	Cough Medicine	Yes	No	Digitalis	Yes	No	Hormones
Yes	No	Insulin or diabetic pills	Yes	No	Iron or poor blood medications	Yes	No	Laxatives
Yes	No	Sleeping pills	Yes	No	Thyroid Medicine	Yes	No	Tranquilizers
Yes	No	Weight reducing/diet pills	Yes	No	Blood thinning pills	Yes	No	Dilantin
Yes	No	Shots	Yes	No	Water pills	Yes	No	Antibiotics
Yes	No	Barbiturates	Yes	No	Birth Control pills	Yes	No	Phenobarbital

Please list the names and dosages of all your medications below:

NAME OF MEDICATION	HOW MANY MGS OR UNITS	HOW OFTEN	FOR WHAT CONDITION

*****PLEASE LIST ANY MEDICATIONS THAT YOU ARE ALLERGIC TO:**

_____
_____
_____
_____
_____

WHAT TYPE OF REACTION DOES IT CAUSE YOU?

_____
_____
_____
_____
_____

Please list any time you have been hospitalized:

NAME OF HOSPITAL	ADDRESS, CITY & STATE	DATES	FOR WHAT

List any surgery that you have had:

Surgery for:	Date	Hospital

List any illnesses that you have had that did NOT require hospitalization:

_____
_____
_____
_____
_____

List any accidents or injuries:

_____
_____
_____
_____
_____

TO BE ANSWERED BY WOMEN ONLY:

Yes No Are you still having regular menstrual periods? Date of your last period_____

Yes No Have you ever had bleeding between your periods? If so when?_____

Yes No Do you have very heavy bleeding with your period?

Yes No Do you feel bloated and irritable before your period?

Yes No Are you now or have you ever taken birth control pills? When?_____

Yes No Have you ever had a miscarriage? When?_____

Yes No Have you ever had discharge from the nipple of your breast? When?_____

Yes No Do you regularly have cancer screening of the cervix (Pap Smear)? Date of last Pap Smear_____

How many times have you been pregnant?_____ How many children were born alive?_____

How many were stillbirths?_____ How many were miscarriages?_____

How many cesarean sections?_____ How many were premature births?_____

Did you have any complications during pregnancy if so what was it?_____

TO BE ANSWERED BY MEN ONLY:

Yes No Have you ever had a prostate exam? Date of last exam _____

Yes No Have you had loss of sexual activity? For how long? _____

Yes No Have you been treated for genital warts? Yes No Have you had discharge from penis?

Yes No Have you had a hernia? When?_____ Yes No Have you had Prostate trouble?

TO BE ANSWERED BY BOTH MEN AND WOMEN:

Yes No Do you suffer from headaches? If so how often?_____ How severe?_____

Yes No Do they cause visual trouble? Yes No Do they occur on one side of the head?

Yes No Do they awaken you from sleep? Yes No Do they feel like a tight head band?

Yes No Does it hurt most in the back of the head and neck? Yes No Does Aspirin relieve them?

_____

Yes No Have you ever fainted? Yes No Have you ever had a seizure or convulsion?

Yes No Do you ever have dizzy spells? Yes No Do you ever have double vision?

Yes No Do you ever have weakness of arms or legs? Yes No Do you ever have pain in your ears?

Yes No Do you ever have ringing in your ears? Yes No Do you ever have nosebleeds?

_____

Yes No Do you frequently have bleeding gums? Yes No Do you frequently have a sore tongue?

Yes No Do you frequently have trouble swallowing? Yes No Do you often have nausea or vomiting?

Yes No Do you frequently have hoarseness?

_____

Have you ever had shortness of breath? Yes No If so continue to answer the following:

Yes No Do you get it doing your usual work? Yes No Do you have a chronic cough?

Yes No While climbing a flight of stairs? Yes No Accompanied by wheezing?

Yes No Which awakens you at night? Yes No Have you ever coughed up blood?

Yes No Do you cough up much sputum? Yes No Does it cause you a dry cough?

_____

Have you ever had chest pain or tightness in the chest? Yes No If so, does it begin with any of the following?

Yes No When exerting yourself. Yes No Does it radiate to the arm?

Yes No When walking against the wind. Yes No Does it disappear at rest?

Yes No When walking up a hill? Yes No Occur 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?

Describe the chest pain or tightness _____

Yes No Do you get palpitations? Yes No Do you sleep on more than one pillow?

_____

Yes No Have you had pain in the stomach? If so, does it:

Yes	No	Occur 1-2 hours after a meal?	Yes	No	Is brought on by eating fried or greasy foods
Yes	No	Awakens you at night?	Yes	No	Is relieved by antacid medications.
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.

If you have had a change in bowel habit recently please answer the following:

Yes	No	Do you get a crampy pain in the abdomen?	When?_____
Yes	No	Alternating diarrhea and constipation?	When?_____
Yes	No	Pain during or after bowel movement?	When?_____
Yes	No	Mucous in the stool?	When?_____
Yes	No	Blood in the stool?	When?_____
Yes	No	Ribbon-like stools?	When?_____
Yes	No	Black Stools?	When?_____
Yes	No	Require use of strong laxatives or enemas?	When?_____

_____

HAVE YOU HAD:

Yes	No	Burning when urinating?	When?_____
Yes	No	Loss of control of bladder?	When?_____
Yes	No	Blood in the urine?	When?_____
Yes	No	Dark colored urine?	When?_____
Yes	No	Trouble starting to urinate?	When?_____
Yes	No	Trouble holding urine?	When?_____
Yes	No	Getting up frequently at night?	When?_____
Yes	No	Passed a kidney stone?	When?_____

_____

HAVE YOU RECENTLY HAD:

Yes	No	Pain in calves or legs when walking?	When?_____
Yes	No	Cramps in legs at night?	When?_____
Yes	No	Pain in the big toe?	When?_____
Yes	No	Varicose Veins?	When?_____
Yes	No	Phlebitis or inflamed leg veins?	When?_____
Yes	No	Swelling in the ankles?	When?_____

_____

BRIEFLY DESCRIBE YOUR PRESENT SYMPTOMS:

_____

_____

_____

_____

_____

_____

_____

_____

_____