PERSONAL HISTORY QUESTIONNAIRE

This information is confidential and will not be released without your authorization.

Date: ________________

Name____ DOB____________________ Age _______
LAST FIRST MIDDLE

Address: ______________________________________APT ________CITY__________________________ZIP________________

Telephone HOME___________________CELL_______________OFFICE_________________EMAIL________________________________

How did you find us?______________________________________ Purpose of this consultation ____________________________________

Ht_________ Wt______ Sex: ___ M___ F Marital status: ___ Single ___Married___ Widowed ___ Other SSN_______________________________

Emergency Contact: ____ who is responsible for charges? ___________________
FIRST AND LAST NAME TELEPHONE RELATIONSHIP

PAST MEDICAL HISTORY: Do you have or have you had? (If yes, give date of occurrence.)

AIDS or HIV	N	Y___________	Bleeding tendencies	N	Y___________	Asthma	N	Y___________
Thyroid	N	Y___________	Blood pressure	N	Y___________	Lupus	N	Y___________
Heart	N	Y___________	Lungs	N	Y___________	Cancer	N	Y___________
Kidneys	N	Y___________	Nervous problems	N	Y___________	Fibromyalgia	N	Y___________
Gallbladder	N	Y___________	Bleeding problems	N	Y___________	Arthritis	N	Y___________
Stomach	N	Y___________	Diabetes	N	Y___________	Scleroderma	N	Y___________
Hepatitis	N	Y___________	Other serious illnesses you have had_______________					

Do you regularly smoke? Y N How much per day?_________________

Do you regularly drink over 3 cups of coffee per day? Y N

Do you regularly drink alcohol or beer? Y N How much per week?__________________

MEDICATIONS: Are you presently taking any of the following? (Circle.)

Aspirin/Anacin	Cough medicine	Antibiotics	Phenobarbital	Dilantin
Bufferin	Thyroid pills	Blood pressure pills	Blood thinners	Iron
Motrin	Hormones	Insulin/diabetic pills	Digitalis	Sleeping pills
Ibuprofen	Birth control pills	Arthritis medication	Cortisone	Water pills

Other medication not listed____

Do you take herbal supplements? Y N If yes, what are they?________________________________

Aspirin and aspirin type products can cause excessive bleeding during surgery.

DRUGS OR SUBSTANCES TO WHICH YOU ARE ALLERGIC____________________________________

FAMILY HISTORY: Have blood relatives had? (Please circle and give reason.)

High blood pressure__________________	Arthritis________________________	Asthma________________________
Diabetes__________________________	Stroke__________________________	Goiter_________________________
Bleeding disorders___________________	Breast cancer____________________	Other cancer____________________

SERIOUS ILLNESSES OR INJURIES: Please list any serious illnesses or injuries and dates.

Illness/Injury__________________________ Year_______ Illness/Injury__________________________ Year________

Illness/Injury__________________________ Year_______ Illness/Injury__________________________ Year________

OPERATIONS: Please list operations and year.

Operation____________________________ Year_______ Operation_____________________________ Year________

Operation____________________________ Year_______ Operation_____________________________ Year________

WOMEN ONLY

Is there a chance you may be pregnant? Y N Regular menses? Y N Date of last menstrual period___________

Any complications with pregnancies?____

How many pregnancies?________ How many children?________ Did you breastfeed? Y N How many?________

Date of last mammogram__________ ☐ Normal ☐ Abnormal

Specify abnormality____

Breast cancer: L R Date_______________ Mastectomy_________________ Date_______________

Breast biopsy: L R Date_______________ Oncologist____

Surgeon for breast biopsy__________________________ Address____

Address_______________________________________

I HAVE READ AND COMPLETED THIS FORM COMPLETELY AND ACCURATELY TO THE BEST OF MY ABILITY

PRINT NAME____ **SIGNATURE** ____