Lakeland Regional Health®

PATIENT'S PERSONAL HISTORY-II

MRN: _____ Date: _____

Confidential Record: Information contained here will not be released unless you authorize us to do so.

Last Name	First Name	Middle		
Birth Date	Country of Birth			
Address	City	State	Zip	
Medicare #	Medicaid #			
Social Security #	Home Phone	Business Phone		
Health Insurance Co.	Insurance #			
Sex: M F	Marital Status	Religion		
Person to Notify	Relationship			
Address	Phone			
Date of Last Physical Examination	Referred By			
Employer				
Spouse's Employer				

FAMILY HISTORY		If Living		If Deceased	
		Age	Health	Age at Death	Cause
Father					
Mother					
Brothers /Sisters	Circle Sex				
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters	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	Rel.		Yes	No	Rel.		Yes	No	Rel.
Stroke	☐	☐		Migraine	☐	☐		Goiter	☐	☐	
Cancer	☐	☐		Asthma	☐	☐		Arthritis	☐	☐	
High blood pressure	☐	☐		Hay fever	☐	☐		Colitis	☐	☐	
Tuberculosis	☐	☐		Emphysema	☐	☐		Nervous breakdown	☐	☐	
Diabetes	☐	☐		Bleeding tendency	☐	☐		Gout	☐	☐	
Leukemia	☐	☐		Heart attack	☐	☐		Rheumatic heart	☐	☐	
Epilepsy	☐	☐		Stomach ulcers	☐	☐		Insanity	☐	☐	
Suicide	☐	☐		Kidney disease	☐	☐		Congenital heart	☐	☐	

PAST HISTORY

Have you had any of the following diseases?

	Yes	No		Yes	No
Rheumatic fever	☐	☐	Frequent kidney or bladder infections	☐	☐
Angina pectoris	☐	☐			
Heart attack	☐	☐	Nervous breakdown	☐	☐
Other heart disease	☐	☐	Thyroid disease	☐	☐
High blood pressure	☐	☐	Stomach ulcers	☐	☐
Anemia	☐	☐	Gallbladder disease	☐	☐
Kidney disease	☐	☐	Jaundice	☐	☐
Gout	☐	☐	Hepatitis	☐	☐
Hay fever	☐	☐	Colitis	☐	☐
Asthma	☐	☐	Arthritis	☐	☐
Frequent lung infections	☐	☐	Migraine headache	☐	☐
Emphysema	☐	☐	Others	☐	☐
Diabetes	☐	☐			
Cancer	☐	☐			

Operations
List and indicate approximate year:

_____

_____

_____

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

_____

_____

_____

PERSONAL HABITS

1. Check if you regularly smoke:

☐Cigarettes ☐Pipe ☐Cigars How long have you been smoking? _____Years
Number per day _____

2.Check if you regularly drink:

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

☐ Beer ☐ 1 bottle per day ☐ 2 bottles ☐ 3 or more

☐ Wine ☐ 1 glass per day ☐ 2 glasses ☐ 3 or more

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

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

5.Do you often awake very early in the morning without apparent cause and find it difficult to fall asleep again? ☐ Frequently ☐ Occasionally ☐ Rarely

Serious Injuries (other than above)
List and give approximate dates:

_____

_____

_____

_____

_____

Diagnostic X-Rays
List and give approximate dates:

_____

_____

_____

_____

_____

Immunization (please give date):

Smallpox _____ Polio _____
Typhoid _____ Tetanus _____

Are you allergic to any medications? Yes ☐ No ☐

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

_____

_____

_____

_____

MEDICATIONS

Check which of the following, if any, you are regularly taking:

☐ Asthma/wheezing medicine	☐ Sleeping pills/tranquilizers
☐ Aspirin, Bufferin, Anacin	☐ Thyroid medicine
☐ Tylenol/similar products	☐ Stomach/digestive medicine
☐ Blood pressure pills	☐ Weight-reducing pills
☐ Cortisone, Prednisone	☐ Blood thinners/Coumadin
☐ Cough medicine	☐ Dilantin
☐ Digitalis/heart medicine	☐ Water pills, diuretics
☐ Hormones/birth control pills	☐ Antibiotics
☐ Insulin/diabetic pills	☐ Phenobarbital/barbituates
☐ Iron/poor-blood medications	☐ Vitamins
☐ Laxatives	☐ Other drugs (list below)

Please list other drugs or injections:

_____

_____

_____

_____

_____

_____

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 supervisors?	☐	☐
Are you unable to perform any work because of a disability?	☐	☐
Are you retired?	☐	☐
If retired, have you had difficulty adjusting to retirement?	☐	☐
If a housewife, do you find your housework difficult?	☐	☐
If a housewife, are you unhappy with your housework?	☐	☐

MARITAL/FAMILY:

Have you been married more than one time?	☐	☐
Has there been a recent change in your marital status?	☐	☐
Does your age and spouse's age differ by more than 10 years?	☐	☐
Are there any problems with your married life?	☐	☐
Do you have any sex problems?	☐	☐
If a widow or widower, have you had difficulty adjusting to your spouse's death?	☐	☐
Do you have any serious problems with your children?	☐	☐
Is your present home life causing unhappiness?	☐	☐
Have there been any deaths in your family or among close friends in the past year or two?	☐	☐
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 the U.S.?	☐	☐
Did you ***not*** complete a high school education?	☐	☐
Did you ***not*** attend and/or complete college?	☐	☐
Were you rejected from 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 excerise less than three times a week?	☐	☐
Do you ***not*** have a hobby or hobbies?	☐	☐
Are you active in political, community, or church activities?	☐	☐

REVIEW OF SYSTEMS

	Yes	No
A. General		
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 itching?	☐	☐
unusually dry skin?	☐	☐
any growth on your skin that bothers you?	☐	☐
any sores or wounds that do not heal?	☐	☐
any change in color or size of warts?	☐	☐
C. Eyes		
Do you:		
have pain in your eyes?	☐	☐
have glaucoma?	☐	☐
have blurry vision?	☐	☐
see halos around lights?	☐	☐
have a change in your vision?	☐	☐
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?	☐	☐
E. Respiratory		
Do you have:		
frequent chest colds?	☐	☐
a constant or bothersome cough?	☐	☐
coughing of blood?	☐	☐
sputum or phlegm between colds?	☐	☐
difficulty breathing?	☐	☐
Have you noticed any wheezing or whistling in your chest?	☐	☐

Please identify your hobby or hobbies:

_____

_____

_____

_____

_____

_____

_____

Additional Comments:

_____

_____

_____

_____

_____

_____

_____

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 your calf muscle 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 changes in your eating habits?	☐	☐
Are there any special foods that cause you to be upset or have stomach pains, nausea, etc.?	☐	☐
Do you tend to burp a lot?	☐	☐
Have you recently noted any trouble swallowing?	☐	☐
Do you have a lot of indigestion or heartburn?	☐	☐
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?	☐	☐
Do you have frequent nausea and/or vomiting?	☐	☐

H. Genitourinary

Do you have:		
anything wrong with your genitals (privates)?	☐	☐
burning or pain when you urinate?	☐	☐
to urinate more frequently?	☐	☐
to pass more urine than you used to?	☐	☐
trouble passing urine?	☐	☐
to get up at night to urinate?	☐	☐
trouble with losing urine when you cough or sneeze?	☐	☐
a problem dribbling urine?	☐	☐
Have you passed blood in your urine?	☐	☐
Have you had an operation to prevent pregnancy? (Vasectomy or sterilization, such as tubal ligation)	☐	☐
Men, do you have prostate gland trouble?	☐	☐

I. Musculoskeletal

	Yes	No
Do you have a problem with back pain?	☐	☐
Do you have pain in your legs or feet?	☐	☐
Does back pain interfere with your work or activities?	☐	☐
Do you have joint pain or stiffness?	☐	☐
Do you have trouble walking or using your hip or knee joints?	☐	☐

J. Central Nervous System

Do you have frequent or severe headaches?	☐	☐
Do you often have spells of dizziness or faintness or light-headedness?	☐	☐
Have you ever seen double?	☐	☐
Do you sometimes lose track of what happens around you for a short time?	☐	☐
Do you sometimes lose the ability to speak for a few seconds?	☐	☐
Have you recently fainted, blacked out or lost consciousness?	☐	☐
Do you have trouble remembering recent events?	☐	☐
Have you ever had convulsions or fits?	☐	☐
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 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

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 use more than 10 pads or have to use a super-size pad or tampon for your periods?	☐	☐
Do you pass clots with your period?	☐	☐
Do you become bloated or gain weight just before your periods?	☐	☐
Have you passed menopause or the change?	☐	☐
Do you have hot flashes?	☐	☐
Have you had any abortions or miscarriages?	☐	☐
Have you had any lumps in your breasts?	☐	☐
Have you had any discharge from your nipples?	☐	☐
Have you ever used an intrauterine device (IUD)?	☐	☐
Have you used other birth control measures?	☐	☐

ADDITIONAL COMMENTS: