Porter Physician Services

Personal History Form

Date _____

Name_____ Age _____ Single ____ Divorced _____

Occupation _____ Married _____ Widowed _____

Birthplace _____ Date of Birth _____

Education: Years High School _____ Years College _____ Post Graduate: _____

Family History	If Living		If Deceased		Has any blood relative ever had:	Who	Please Circle	
	Age	Health	Age at Death	Cause				
Father					Cancer		No	Yes
Mother					Tuberculosis		No	Yes
Brother or Sister:					Diabetes		No	Yes
1					Heart trouble		No	Yes
2					High blood pressure		No	Yes
3					Bleeding tendency		No	Yes
4					Stroke		No	Yes
5					Epilepsy		No	Yes
Husband or Wife					Nervous breakdown		No	Yes
Son or Daughter					Suicide		No	Yes
1					Goiter		No	Yes
2					**Note:** This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.			
3								
4								
5								

Personal History - Have you had any of the following: (Please circle yes or no)

						SURGERY - Have you had:		
Measles	No	Yes	Nervous breakdown	No	Yes	Tonsillectomy	No	Yes
German Measles	No	Yes	Food, chemical or drug poisoning	No	Yes	Appendectomy	No	Yes
Mumps	No	Yes	Hay fever or asthma	No	Yes	Other	No	Yes
Chicken Pox	No	Yes	Hives or exczema	No	Yes			
Whooping cough	No	Yes	Frequent infections or boils	No	Yes			
Scarlet fever/Scarletina	No	Yes	Frequent colds or sore throat	No	Yes			
Diphtheria	No	Yes	Any other disease	No	Yes			
Smallpox	No	Yes	ALLERGIES:	None				
Pneumonia	No	Yes	Medicine:					
Influenza	No	Yes				Have you been advised to have any surgical operation which has not been done?	No	Yes
Pleurisy	No	Yes						
Rheumatic fever or heart disease	No	Yes						
Arthritis or Rheumatism	No	Yes	Other Allergies:			Please Explain:		
Any bone or joint disease	No	Yes						
Neurities or neuralgia	No	Yes						
Bursitis, Sciatica or Lumbago	No	Yes						
Polio or Meningitis	No	Yes						
Kidney disease	No	Yes	INJURIES - Have you had:					
Gonorrhea or Syphilis	No	Yes	Broken or cracked bones	No	Yes	Have you been hosptialized for any other illness?	No	Yes
Anemia	No	Yes	Sprains	No	Yes			
Jaundice	No	Yes	Lacerations	No	Yes	Please Explain:		
Epilepsy	No	Yes	Dislocations	No	Yes			
Migraine Headaches	No	Yes	Concussion or head injury	No	Yes			
Tuberculosis	No	Yes	Ever been knocked unconscious?	No	Yes			
Diabetes	No	Yes	WEIGHT: Now One year ago					
Cancer	No	Yes	Maximum When?	No	Yes			
High or Low Blood Pressure	No	Yes	Blood or Plasma Transfusion	No	Yes			

Patient/Guardian Signature: _____ Reviewed by Physician: _____ Date: _____

Personal Health History, Page 2 of 2 Patient Name: MD Initials: _____

X-RAYS - Have you ever had x-rays of:		
Chest	No	Yes
Stomach or colon	No	Yes
Gall Bladder	No	Yes
Extremities	No	Yes
Back	No	Yes
Teeth	No	Yes
Other:	No	Yes
EKG: Have you ever had an EKG?	No	Yes
IMMUNIZATIONS Have you had:		
Smallpox within last 7 years	No	Yes
Tetanus ? When?	No	Yes
Polio ? How many shots?	No	Yes
SYSTEMS REVIEW		
Have you had any of the following:		
EYES		
Eye strain	No	Yes
Seeing double	No	Yes
Seeing halo around lights	No	Yes
EARS		
Hearing loss	No	Yes
Inections	No	Yes
Ringing in ears	No	Yes
Earache or discharge	No	Yes
THROAT AND MOUTH		
Frequent sore throat	No	Yes
Hoarseness	No	Yes
Bleeding gums	No	Yes
NECK		
Goiter	No	Yes
Lump or swelling	No	Yes
Pain orstiffness	No	Yes

BREASTS		
Lump or swelling	No	Yes
Discharge	No	Yes
Pain or stiffness	No	Yes
HEART AND LUNGS		
Chronic cough	No	Yes
Coughing up blood	No	Yes
Shortness of breath	No	Yes
Night sweats	No	Yes
Chest pain or pressure	No	Yes
Palpitations or fluttering	No	Yes
Swollen ankles	No	Yes
INTESTINAL		
Loss of appetite		
Trouble swallowing	No	Yes
Nausea or vomiting	No	Yes
Vomiting blood	No	Yes
Pain in abdomen	No	Yes
Gallbladder trouble	No	Yes
Belching or bloating	No	Yes
Change in bowel habits	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Blood in stools or hemorrhoids	No	Yes
Black (tarry) stools	No	Yes
KIDNEY, BLADDER, GENITALS		
Albubin (protein) or sugar in urine	No	Yes
Blood or pus in urine	No	Yes
Kidney or bladder infection	No	Yes
Urinating at night (___ times)	No	Yes
Trouble starting urine stream	No	Yes
Discharge	No	Yes
Sexual problems?	No	Yes

MENSTRUATION (Women only)		
Age of onset of periods		
When was your last period?		
When was your previous period?		
How long is your period?		
How many pads/tampons per day?		
Usual interval between perods? _____ days		
Bleading between periods		
Pain with periods		
NEUROLOGICAL		
Fequent headaches	No	Yes
Fainting spells	No	Yes
Convulsions	No	Yes
Paralysis or weakness	No	Yes
Dizzy spells	No	Yes
EXTREMITIES		
Arthritis	No	Yes
Varicose veins	No	Yes
Cramps in legs	No	Yes
GENERAL		
Unusual fatigue	No	Yes
Unusual weakness	No	Yes
Abnormal thirst	No	Yes
Unable to sleep	No	Yes
Anemia	No	Yes
Swollen glands	No	Yes
Skin trouble	No	Yes
Back pain	No	Yes
OTHER:		

HABITS
Coffee # Cups per day_____
Smoking
Cigarettes # Packs per day _____
Cigars Yes No Other Yes No
Alcoholic beverages
Present: Light ___ Moderate ____ Heavy ____
Past: Light ___ Moderate ____ Heavy ____
Work: # hours per day _____
Regular exercise No Yes
Hobby?

Current Medications:

Current Medications (continued):

Advance Directive: Livng Will DNR Healthcare Rep/Power of Attorney
Other: