

# Perimeter North Family Medicine Patient's Personal History Form

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Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_  
 Occupation \_\_\_\_\_ Birthplace \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Date of Last Physical Examination \_\_\_\_\_

Chief Complaints, if any. (Please list all symptoms):

1. \_\_\_\_\_ 3. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_

Please answer each of the following questions by placing a  in the appropriate box. Answer when or who questions when applicable.

### FAMILY HISTORY

Has any blood relative ever had:

- |                            |                             |                              |           |
|----------------------------|-----------------------------|------------------------------|-----------|
| Cancer, including leukemia | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| What kind _____            |                             |                              |           |
| Tuberculosis               | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Diabetes                   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Heart Trouble              | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Heart Attack               | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| High Blood Pressure        | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Stroke                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Epilepsy                   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Bleeding Disorder          | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Asthma                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Allergies                  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Liver Disease              | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Migraine Headaches         | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Alcoholism                 | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Emphysema                  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Stomach or Duodenal Ulcer  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Kidney Disease             | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Glaucoma                   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Sickle Cell Anemia         | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Other Anemia               | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Mental Illness             | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Suicide                    | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Birth Defects              | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |
| Other Serious Disease      | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who _____ |

### PERSONAL HISTORY

- Do you smoke?  No  Yes  
 What \_\_\_\_\_ How much \_\_\_\_\_
- Do you drink caffeine?  No  Yes  
 How much \_\_\_\_\_
- Do you exercise?  No  Yes  
 How Frequently \_\_\_\_\_
- Do you use recreational drugs?  No  Yes  
 What \_\_\_\_\_ How often \_\_\_\_\_
- Do you drink:  
 Beer  No  Yes How many per week? \_\_\_\_\_  
 Wine  No  Yes How many glasses per week? \_\_\_\_\_  
 Other Alcoholic Beverages  No  Yes  
 How many drinks per week? \_\_\_\_\_
- Are you on a special diet?  No  Yes  
 What diet? \_\_\_\_\_
- Do you wear a seat belt?  No  Yes  
 How often? \_\_\_\_\_
- Do you own a gun?  No  Yes
- Do you have a living will?  No  Yes

Relative	Living	Dead	Age at Death	Cause of Death
Father				
Mother				
Brother or Sister				
Spouse				
Son or Daughter				

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**PERSONAL HISTORY (continued)**

Have you lost weight in the last year?  No  Yes  
 Do you have difficulty Sleeping?  No  Yes  
 Are you Overweight?  No  Yes

**X-RAYS**

Have you had any of these X-rays? If yes, when?

Chest  No  Yes When \_\_\_\_\_  
 Stomach  No  Yes When \_\_\_\_\_  
 Colon  No  Yes When \_\_\_\_\_  
 Gall Bladder  No  Yes When \_\_\_\_\_  
 Back  No  Yes When \_\_\_\_\_  
 Kidney  No  Yes When \_\_\_\_\_  
 Extremities  No  Yes When \_\_\_\_\_  
 Other \_\_\_\_\_  No  Yes When \_\_\_\_\_

Have you ever had X-ray treatments?  No  Yes When \_\_\_\_\_

**IMMUNIZATIONS**

Have you ever been immunized against:

Small Pox  No  Yes Last Shot \_\_\_\_\_  
 Tetanus  No  Yes Last Shot \_\_\_\_\_  
 Polio (shots or oral vaccine)  No  Yes Last Shot \_\_\_\_\_  
 Measles  No  Yes Last Shot \_\_\_\_\_  
 German Measles  No  Yes Last Shot \_\_\_\_\_  
 Other \_\_\_\_\_  No  Yes Last Shot \_\_\_\_\_

**ALLERGIES**

Are you allergic to any of the following:

Penicillin  No  Yes  
 Sulfa  No  Yes  
 Other Antibiotics  No  Yes What \_\_\_\_\_  
 Any Other Drug or Medicine  No  Yes What \_\_\_\_\_  
 Any Food  No  Yes What \_\_\_\_\_  
 Nail Polish or Cosmetic  No  Yes  
 Other \_\_\_\_\_  No  Yes

**MEDICINES**

Are you taking any prescription medicines regularly now?  No  Yes What \_\_\_\_\_

Are you taking any over the counter medicines?  No  Yes What \_\_\_\_\_

Are you taking any herbal medicines?  No  Yes What \_\_\_\_\_

**MEDICINES (continued):**

Have you ever taken:

Insulin  No  Yes When \_\_\_\_\_  
 Cortisone  No  Yes When \_\_\_\_\_  
 Thyroid medicine  No  Yes When \_\_\_\_\_  
 Male or Female Hormones  No  Yes When \_\_\_\_\_  
 Blood Pressure Medicine  No  Yes When \_\_\_\_\_  
 Tranquilizers or Sedatives  No  Yes When \_\_\_\_\_  
 Birth Control Pills  No  Yes When \_\_\_\_\_  
 Other \_\_\_\_\_  No  Yes When \_\_\_\_\_

**DEVICES**

Do you use:

Eyeglasses  No  Yes  
 Contact lenses  No  Yes  
 Hearing Aid  No  Yes  
 Dentures  No  Yes  
 Neck Brace  No  Yes  
 Back Brace  No  Yes  
 Other Brace  No  Yes  
 Artificial Limb  No  Yes  
 Truss  No  Yes  
 Pacemaker  No  Yes  
 IUD  No  Yes  
 Diaphragm  No  Yes  
 Other Device  No  Yes What \_\_\_\_\_

**OPERATIONS**

Have you had surgery on any of the following:

Tonsils  No  Yes When \_\_\_\_\_  
 Appendix  No  Yes When \_\_\_\_\_  
 Gall Bladder  No  Yes When \_\_\_\_\_  
 Stomach  No  Yes When \_\_\_\_\_  
 Small Intestine  No  Yes When \_\_\_\_\_  
 Kidney  No  Yes When \_\_\_\_\_  
 Colon  No  Yes When \_\_\_\_\_  
 Thyroid  No  Yes When \_\_\_\_\_  
 Hernia (Rupture)  No  Yes When \_\_\_\_\_

Women:

Breast  No  Yes When \_\_\_\_\_  
 Uterus  No  Yes When \_\_\_\_\_

Ovaries  No  Yes When \_\_\_\_\_

Men:

Prostate  No  Yes When \_\_\_\_\_  
 Other \_\_\_\_\_  No  Yes When \_\_\_\_\_

**DIAGNOSED DIFFICULTIES:**

Do you now, or have you in the past, had any of the following:

Migraine headaches  No  Yes (now)  Yes (past) When \_\_\_\_\_  
 Epilepsy or Convulsions  No  Yes (now)  Yes (past) When \_\_\_\_\_  
 Stroke  No  Yes (now)  Yes (past) When \_\_\_\_\_  
 Glaucoma  No  Yes (now)  Yes (past) When \_\_\_\_\_  
 Cataracts  No  Yes (now)  Yes (past) When \_\_\_\_\_  
 Blindness (either eye)  No  Yes (now)  Yes (past) When \_\_\_\_\_  
 Ear Infections  No  Yes (now)  Yes (past) When \_\_\_\_\_  
 Deafness  No  Yes (now)  Yes (past) When \_\_\_\_\_  
 Asthma  No  Yes (now)  Yes (past) When \_\_\_\_\_  
 Hay fever  No  Yes (now)  Yes (past) When \_\_\_\_\_  
 Chronic Bronchitis  No  Yes (now)  Yes (past) When \_\_\_\_\_  
 Emphysema  No  Yes (now)  Yes (past) When \_\_\_\_\_  
 Tuberculosis  No  Yes (now)  Yes (past) When \_\_\_\_\_

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**DIAGNOSED DIFFICULTIES (continued):**

- Abnormal Chest X-ray  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Heart Murmur as an Adult  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Abnormal Electrocardiogram  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Enlarged Heart  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Heart Attack  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Rheumatic Fever  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Angina  No  Yes (now)  Yes (past) When \_\_\_\_\_
- High Blood Pressure  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Gall Stones  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Hepatitis  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Cirrhosis of Liver  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Stomach or Duodenal Ulcer  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Abnormal Stomach X-ray  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Colon or Bowel Trouble  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Rectal Trouble  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Hemorrhoids or Piles  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Dysentery or Serious Diarrhea  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Kidney or Bladder infection  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Kidney Stones  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Other Kidney Disease  No  Yes (now)  Yes (past) When \_\_\_\_\_

What \_\_\_\_\_  
Anemia  No  Yes (now)  Yes (past) When \_\_\_\_\_

What kind \_\_\_\_\_

- Poor Blood Clotting  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Diabetes  No  Yes (now)  Yes (past) When \_\_\_\_\_
- On Insulin  No  Yes Dosage \_\_\_\_\_
- Gout  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Overactive Thyroid  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Underactive Thyroid  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Goiter  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Broken Bones  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Varicose Veins  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Arthritis  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Polio  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Phlebitis  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Syphilis or VD  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Gonorrhea  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Recurrent Boils  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Other Skin Disease  No  Yes (now)  Yes (past) When \_\_\_\_\_

What \_\_\_\_\_

- Serious Depression  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Serious Emotional Problem  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Nervous Breakdown  No  Yes (now)  Yes (past) When \_\_\_\_\_

**Women:**

- Menstrual Difficulties  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Ovarian Cyst  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Other Gynecological Problems  No  Yes (now)  Yes (past) When \_\_\_\_\_

What \_\_\_\_\_

Age at First Period \_\_\_\_\_

Still Menstruating?  No  Yes

    Are Periods Regular  No  Yes

    Age Periods Stopped \_\_\_\_\_

    Why Periods Stopped \_\_\_\_\_

- Cystitis  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Mastitis  No  Yes (now)  Yes (past) When \_\_\_\_\_
- Breast Cancer  No  Yes (now)  Yes (past) When \_\_\_\_\_

Number of Times Pregnant \_\_\_\_\_

Number of Children \_\_\_\_\_

Number of Miscarraiges \_\_\_\_\_

**Men:**

Prostate Trouble  No  Yes (now)  Yes (past) When \_\_\_\_\_

Other Illness  No  Yes (now)  Yes (past) When \_\_\_\_\_

What \_\_\_\_\_

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## SYSTEM REVIEW

Do you have any of the following complaints?

### General

Fever  No  Yes  
 Chills  No  Yes  
 Aches or Pains  No  Yes  
 General Weakness  No  Yes  
 Memory Loss  No  Yes  
 Swollen Glands  No  Yes  
 Easy Bruising  No  Yes

### Head

Blurred Vision Not Corrected by Glasses  No  Yes  
 Double Vision  No  Yes  
 Light Flashes  No  Yes  
 Halos Around Lights  No  Yes  
 Pain In the Eyes  No  Yes  
 Ear Pain  No  Yes  
 Drainage From Ear(s)  No  Yes  
 Nosebleeds Not Due to Injury  No  Yes  
 Sinus Trouble  No  Yes  
 Difficulty Swallowing  No  Yes  
 Mouth, Tooth or Tongue Problems  No  Yes  
 Persistent Hoarseness  No  Yes

### Skin

Changing Mole  No  Yes  
 Rash  No  Yes  
 Yellow Skin  No  Yes  
 Other \_\_\_\_\_  No  Yes

### Neck

Swelling  No  Yes  
 Lumps  No  Yes  
 Stiffness  No  Yes  
 Other \_\_\_\_\_  No  Yes

### Gastrointestinal

Poor Appetite  No  Yes  
 Indigestion or Heartburn  No  Yes  
 Difficulty Swallowing  No  Yes  
 Nausea or Vomiting  No  Yes  
 Vomiting Blood  No  Yes  
 Abdominal Pain or Cramps  No  Yes  
 Abdominal Swelling  No  Yes  
 Diarrhea  No  Yes  
 Constipation  No  Yes  
 Change in Bowel Habits  No  Yes  
 Pass Blood from Rectum  No  Yes  
 Black, Tar-like Bowel Movements  No  Yes  
 Other \_\_\_\_\_  No  Yes

### Chest, Heart, Lungs

Shortness of Breath  No  Yes  
 Poor Exercise Tolerance  No  Yes  
 Fluttering of Heart  No  Yes  
 Unusual Heartbeat  No  Yes  
 Chest Pain or Pressure Attacks  No  Yes  
 Frequent Cough  No  Yes  
 Coughing up Blood  No  Yes  
 Wheezing  No  Yes  
 Night Sweats  No  Yes  
 Swollen Ankles  No  Yes  
 Leg Cramps  No  Yes  
 Other \_\_\_\_\_  No  Yes

### Kidney

Blood in Urine  No  Yes  
 Pain or Burning While Urinating  No  Yes  
 Difficulty Passing Urine  No  Yes  
 Difficulty Controlling Urine  No  Yes  
 Getting up at Night to Urinate  No  Yes  
 Other \_\_\_\_\_  No  Yes

### Women:

Breast Lump  No  Yes  
 Discharge from Nipple  No  Yes  
 Other Breast Problem  No  Yes  
 Vaginal Discharge  No  Yes  
 Vaginal Bleeding or Spotting (other than periods)  No  Yes  
 Hot Flashes  No  Yes  
 Pain with Intercourse  No  Yes  
 Possibly Pregnant  No  Yes  
 Change in Periods  No  Yes  
 Pain not associated with Periods  No  Yes  
 Other \_\_\_\_\_  No  Yes

### Men:

Breast Lump  No  Yes  
 Discharge from Penis  No  Yes  
 Sore on Penis  No  Yes  
 Lump in Testicles  No  Yes  
 Difficulty Having Erections  No  Yes  
 Other \_\_\_\_\_  No  Yes

### Muscular

Weakness in Arm or Leg  No  Yes  
 Difficulty with Balance  No  Yes  
 Dizzy Spells  No  Yes  
 Speech Difficulty  No  Yes  
 Fainting Spells  No  Yes  
 Other \_\_\_\_\_  No  Yes

### Bones-Joints

Painful Joints  No  Yes  
 Swollen Joints  No  Yes  
 Loss of Muscle Strength  No  Yes  
 Lump or Swelling in Muscle  No  Yes  
 Lump on Bone  No  Yes  
 Back Pain  No  Yes  
 Other \_\_\_\_\_  No  Yes

### Endocrine

Thirsty All the Time  No  Yes  
 Cold Most of the Time  No  Yes  
 Too Warm Most of the Time  No  Yes  
 Unusually Tired or Sluggish  No  Yes  
 Unusually Jumpy or Nervous  No  Yes

### Psychological

Do you find your life:  
 Generally Unsatisfactory  No  Yes  
 Too Demanding  No  Yes  
 Boring  No  Yes  
 Satisfactory  No  Yes

Do you worry about:  
 Money  No  Yes  
 Job  No  Yes  
 Marriage  No  Yes  
 Home Life  No  Yes  
 Children  No  Yes

Do you:  
 Cry Easily  No  Yes  
 Feel Inferior to Others  No  Yes  
 Feel Shy  No  Yes  
 Feel Things Go Wrong  No  Yes  
 Often Depressed  No  Yes  
 Have Irrational Fears  No  Yes  
 Feel Anxious or Upset  No  Yes

Have You:  
 Seriously Considered Suicide  No  Yes  
 Attempted Suicide  No  Yes