Eagle Physicians @ Lake Jeanette

PERSONAL HISTORY QUESTIONNAIRE

Today's Date:____/____/____

Name: _____ Date of Birth:____/____/____
Last First Middle/Maiden

Sex: Male____ Female____ Marital Staus: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
(Please check(✓) one)

Home Address: _____ City_____State _____ Zip_____

Home Telephone Number: ( ) _____ -_____ Business Number: ( ) _____ - _____

Employer: _____ Occupation: _____

GENERAL HEALTH INFORMATION

Who referred you to Eagle Physicians @ Lake Jeanette: _____

Describe your present state of health: Excellent_____ Good_____ Fair_____ Poor_____

If not presently in good health, when were you last in good health?_____

Mood: Do you consider yourself: ❑ Happy ❑ Depressed ❑ Nervous ❑ Worried ❑ Shy ❑ Perfectionist
(Please check (✓) all that apply)

MEDICAL HISTORY

Weight: Present:_____ Usual:_____ Maximum:_____

Are you allergic to any of the following: ❑ Penicillin ❑ Sulfa ❑ Aspirin ❑ Codeine ❑ -mycins ❑ Novocaine
Any other allergies to medicines? _____

Please list any **medication** (prescription & non-prescription) you have taken in the past year:

	Name	Dosage (mg)	How frequently?	For what problem?
1				
2				
3				
4				
5				
6				
7				
8				

If more space is needed, place a (✓) here ❑ and continue on the back of the page

List your **chronic medical problems** (for example, high blood pressure, diabetes, asthma, cholesterol)

1		8	
2		9	
3		10	
4		11	
5		12	
6		13	

If more space is needed, place a (✓) here ❑ and continue on the back of the page

SURGERY

	Type of Surgery	Date	Hospital / Surgeon
1			
2			
3			
4			

If more space is needed, place a (✓) here ❑ and continue on the back of the page

INJURIES

	Type of Injury	Body part	Date	Treatment
1				
2				
3				

If more space is needed, place a (✓) here ❑ and continue on the back of the page

HOSPITALIZATIONS

	Illness	Date	Hospital / Doctor
1			
2			
3			

If more space is needed, place a (✓) here ❑ and continue on the back of the page

When did you last have the following immunizations? Tetanus _____ Influenza _____
Pneumococcal vaccine ("pneumonia shot") _____ Hepatitis B _____
Mumps, Measles & Rubella (MMR) _____

Have you had transfusions or received blood? _____ If yes, when? _____

When did you have your last: EKG_____ Chest X-Ray_____ Pap Smear _____
Mammogram _____ Blood tests _____ Sigmoidoscopy _____

Do you have a Living Will? _____ Do you have a health care Power of Attorney?

SOCIAL HISTORY

Habits				NOW?
Tobacco	What kind? _____	How much? _____	How Long? _____	Y / N
Alcohol	What kind? _____	How much? _____	How Long? _____	Y / N
Caffeine	What form? _____		How much per day? _____	
"Recreational" Drugs (marijuana, cocaine, LSD, etc.)	What kind? _____	How much? _____	How Long? _____	Y / N

Daily diet: _____
Sleep: ❑ Restful ❑ Restless How may hours per night? _____

Education (years) High School _____ College _____ Graduate School_____

Hobbies: (list)_____

FAMILY HISTORY

Immediate Family

Spouse	Name	Age	Health

Children	Name	Sex	Age	Health

If more space is needed, place a (✓) here ❑ and continue on the back of the page

Other family history: Complete the chart below and clarify by (✓) brother or sister.

	If living, present age	If deceased, age at death	Health? Good, fair or poor	Cancer? Type?	High Blood Pressure	Heart Disease	Diabetes	Other
Father								
Mother								
❑ Brother ❑ Sister								
❑ Brother ❑ Sister								
❑ Brother ❑ Sister								
❑ Brother ❑ Sister								

If more space is needed, place a (✓) here ❑ and continue on the back of the page

In addition to the above, have any "blood" relatives had any of the following? (please ✓)

❑ Diabetes ❑ TB ❑ Colon cancer ❑ Breast cancer ❑ Ovarian cancer ❑ Other cancer
❑ High blood pressure ❑ Heart trouble ❑ Heart attack before age 50 ❑ Anemia
❑ Kidney disease ❑ Ulcer ❑ Arthritis ❑ Mental illness
Other family conditions: _____

Why did you make this appointment to see the doctor? Please describe the medical problems, concerns and / or symptoms you have presently:

_____
_____
_____
_____
_____