ADULT PERSONAL HISTORY FORM

If you intend to establish yourself as a patient in The Health Care Institute of North Florida, the following information will be essential in assisting your physician in discovering family tendencies towards certain diseases and silent illnesses of which you may be unaware. This information will also enable your physician to plan for your long term medical care and will provide necessary information should you become acutely ill and not be able to communicate your symptoms or past medical history.

NOTE: This History Form is a **CONFIDENTIAL** record and will not be released without your permission. PLEASE be as ACCURATE and THOROUGH as possible. We apologize for the length of the form but it is very important.

● IDENTIFYING DATA ●

Name _____ Age Today _____ Gender _____ Race _____

Marital Status (Circle one) Married Single Divorced Widow(er)

Present Employer _____ Occupation _____

Number of children _____ number of boys _____ number of girls _____ number living at home now ____

Date you last saw physician _____ Reason for that visit _____

● HISTORY OF PRESENT ILLNESS ●

List the single most important symptoms or reason for your visit today _____

_____

List all other symptoms or problems that you would like to have addressed: _____

_____

_____

● PRESENT MEDICATIONS ●

	Name of Drug	Why Given? (What disease or medical problem)	How long taken?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

(Use additional space on last page of this form, if necessary; please list over-the-counter – non-prescription medicines also.)

● CHILDHOOD ILLNESSES ●

(Birth to 17 years of age)

	Yes	No
1. Convulsions; fits, epilepsy		
2. Rheumatic fever		
3. Pneumonia		
4. Repeated ear infections		
5. Birth defects What kind? Explain. _____ _____		
6. Meningitis		
7. Anemia		
8. Any other childhood illnesses? Explain. _____ _____ _____ _____		

● ADULT MEDICAL ILLNESSES ●

(17 years of age or older)

Have you ever had:	Yes	No
1. Hives		
2. Eczema		
3. Frequent skin infections		
4. Psoriasis		
5. Other skin diseases Explain. _____		
6. Glaucoma		
7. Cataracts		
8. Other eye diseases Explain. _____		
9. Pneumonia		
10. Tuberculosis or positive skin test For TB (Tine, PPD)		
11. Emphysema		
12. Abnormal chest x-ray Explain. _____		
13. Asthma		
14. Other lung disease		
15. Rheumatic fever		
16. High blood pressure		
17. Heart attack		
18. Other heart disease Explain. _____		
19. Stomach ulcers		
20. Hiatal hernia		
21. Diverticulitis, diverticulosis		
22. Irritable bowel syndrome		
23. Gallstones		
24. Hepatitis		
25. Jaundice		
26. Other intestinal diseases Explain. _____		
27. Frequent or recurrent urinary tract infections		
28. Prostatitis		
29. Enlarged prostate		
30. Syphilis		
31. Gonorrhea		
32. Other kidney or urinary tract diseases Explain. _____		
33. Arthritis		
34. Osteoporosis		
35. Scoliosis		
36. Other bone or joint diseases		
37. Meningitis		
38. Seizure, epilepsy (fits)		
39. Neuritis, neuralgia		
40. Stroke		
41. Anxiety, insomnia, nervousness		
42. Depression requiring medicine		
43. Other diseases of the nervous system Explain. _____		
44. Diabetes		
45. Cancer		
46. Goiter: Low or high thyroid condition		
47. Anemia		
48. Blood transfusions When, why, how many units? _____		
49. Breast disease		
50. Vaginal or uterine disease		
51. Any other female diseases Explain. _____		

● HOSPITALIZATIONS ●

(List all hospitalizations except for surgical admission. See Surgical history below for pure surgical admissions.)

YEAR	DOCTOR	HOSPITAL, CITY	DIAGNOSIS (REASON FOR ADMISSION)

(Use last page if necessary.)

● SURGICAL HISTORY ●

YEAR	DOCTOR	HOSPITAL, CITY	TYPE OF SURGERY

(Use last page if necessary.)

● ACCIDENTS OR SIGNIFICANT INJURIES ●

(Include workman's compensation injuries, athletic injuries and other significant injuries which led to medical treatment)

1. _____
2. _____
3. _____
4. _____

(Use last page if necessary.)

● IMMUNIZATIONS ●

	(Age or date given)		(Age or date given)
Tetanus shot	_____	Last tuberculosis skin test	_____
Measles shot	_____	Last flu shot	_____
Mumps shot	_____	Pneumonia shot	_____
Rubella shot	_____	Hepatitis "B" shot	_____
HIB (hemophilus influenza)	_____	Other shots or immunization	_____

● FAMILY HISTORY ●

INFORMATION: This is a general list of the types of diseases that if a family member has may be medically important: Cancer of any type; diabetes (sugar); high blood pressure; insanity; suicide; alcohol or drug abuse; heart disease; heart attack, bypass surgery; kidney failure; congestive heart failure; seizure; leukemia; colon cancer; breast cancer; melanoma.

RELATIVE	AGE NOW If ALIVE	LIST ALL SERIOUS MEDICAL PROBLEMS AND IF DEAD, CAUSE OF DEATH	APPROXIMATE AGE OF DEATH
FATHER			
MOTHER			
SISTER(S)			
BROTHER(S)			

Has any other relative living or dead had any of the diseases listed below?
Please enter relationship and any other information about the disease.
(Example: Maternal grandmother, breast cancer, age 34)

1. Cancer _____
2. Diabetes _____
3. Heart disease (What kind?) _____
4. High blood pressure _____
5. Epilepsy _____
6. Insanity or other mental illnesses _____
7. Suicide _____
8. Alcoholism _____
9. Drug abuse _____
10. Other (describe) _____

● SOCIAL AND PERSONAL HISTORY; HABITS, ETC. ●

Have you ever lived in a foreign country? (List) _____

Have you traveled out of continental U.S. in last 2 years? (List places or countries) _____

How much caffeine do you drink? (tea, coffee, cokes, etc.) (cups or drinks per day) _____

Are you exposed to any toxic substances at home or work? (List) _____

Did you ever smoke? ____ Do you currently smoke? _____ (yes/no) age started _____; number packs per day _____

Did you ever drink alcohol? _____ Do you currently drink alcohol? _____ (yes/no) beer, wine, mixed drinks (circle)

Number of drinks per day average _____. Do you ever get drunk? _____ (yes/no); how often? _____

Have you ever used any street drugs such as marijuana, cocaine, etc.? (List) _____

● ALLERGIES ●

NAME OF DRUG	TYPE OF ALLERGIC REACTION (Rash, breathing, nausea, abdominal pain, etc.)

● REVIEW OF SYSTEMS ●

SKIN●HAIR●NAILS Yes No

1. Changes in size or color of skin lumps or growths you are concerned about
2. Frequent or persistent infections of skin
3. Unusual hair loss
4. Recurrent rashes
   Where? _____

LYMPHATIC●HEMATOPOIETIC

5. Blood transfusions
   How many times? _____
6. Spontaneous bleeding
7. Prolonged bleeding after a cut
8. Any lymph nodes that did not go away

HEAD●EYES●EARS●NOSE●THROAT

9. Frequent headaches
10. Ringing in ears
11. Hearing loss
12. Do you wear glasses?
    Date eyes last checked: _____
    By whom? _____
13. Nose bleeds

THORAX●BREAST●LUNGS

14. Pain in breasts
15. Lumps in breasts
16. Pain in rib cage
17. Persistent cough
18. Do you cough up sputum every morning?
    How much (teaspoon, tablespoon)? _____
19. Night sweats
20. Date last chest x-ray _____

CARDIOVASCULAR●VASCULAR

21. Chest pain
22. Shortness of breath
    How many pillows do you sleep on? _____
23. Swelling of feet
24. Fluttering of heart
25. Leg cramps at night
26. Leg cramps while walking

Yes No

27. Fainting
28. Told you had a heart murmur or hole in your heart
29. Told you had blockage in neck blood vessels

GASTROINTESTINAL

30. Recent increase or decrease in appetite
31. Vomiting or nausea
32. Belching, gas
33. Heartburn
34. Abdominal pain
35. Diarrhea
36. Constipation
37. Frequent use of laxatives
    What laxatives do you use? _____
38. Recent change in bowel habits
    Describe. _____
39. Blood in stool or when you wipe from a bowel movement
40. Hemorrhoids
41. Hernia

MUSCULOSKELETAL

42. Pain and swelling in joints
    List the main joints involved _____
43. Other joint problems
    List. _____
44. Burning on urination
45. Difficulty in starting urinary stream
46. Discharge (leaking) from penis
47. Vaginal discharge
48. Pain with intercourse (sex)
49. Leaking of urine when coughing, sneezing or straining
50. Any blood in urine
51. Any bed wetting
52. What do you use to prevent pregnancy? _____
53. How many times do you get up at night to urinate? _____

NERVOUS SYSTEM; PSYCHOLOGICAL Yes No

54. Convulsion, fits or seizures
55. Fainting
56. Paralysis
57. Numbness
58. Anxiety, depression
59. Inability to sleep

ENDOCRINE

60. Excessive sweating
61. Inadequate erection
62. Decreased sexual drive or loss of interest in sex
63. Excessive thirst
64. Unusual increase in appetite
65. Weight loss
66. Weight gain

OBSTETRICAL, GYNECOLOGICAL Yes No

67. Age first menstrual period started _____
68. Are your periods regular (i.e., approximately 1 period each 24-35 days)?
69. Any clots with periods
70. Any pain with periods
71. Describe flow: (heavy, light, moderate) _____
72. How many days do your periods last (average)? ___
73. Date of your last period. _____
74. Number of times pregnant including miscarriages __
75. Children living now _____
76. List any children that have died (age, cause) _____
    _____
77. Number of C-sections _____
78. Number of premature births _____
79. What approximate age did your periods completely stop? _____
80. Do you have hot flashes?
81. Any lumps in your breasts
82. Discharge or leaking from your breasts

Please list any comments about your general health or any specific problems that you would like to discuss in more detail or any continuation of partially answered questions earlier on this form.