Endwell Family Physicians

PATIENT'S PERSONAL HISTORY
CONFIDENTIAL

Name_____

Date of Birth_____

List any specialists you are currently seeing: _____

_____

PERSONAL HISTORY
In the appropriate column, place an (X) next to any illness that you have now or have had in the past.

You	Illness
	Asthma
	Allergies
	Tuberculosis
	Heart Problem
	High Blood Pressure
	Diabetes
	High Cholesterol
	Bladder
	Kidney Problem
	Convulsions
	Epilepsy
	Stroke
	Mental Illness
	Thyroid
	Cancer
	Bleeding Tendency
	Alcoholism
	German Measles
	Measles
	Mumps
	Polio
	Chickenpox
	Rhematic Fever
	Bronchitis
	Pneumonia
	Emphysema
	Ulcer
	Yellow Jaundice
	Hepatitis
	Liver Disease
	Malaria
	Pancreatitis
	Diverticulitis
	Hemorrhoids
	Hernia
	Prostate Problem
	Eczema
	Skin Problem
	Neuralgia
	Headaches
	Eye Disorder
	Ear Disorder
	Arthritis
	Bone Disease
	Osteoporosis
	Gout
	Anemia
	Vein Trouble
	Phlebitis
	Sexually Transmitted Disease

HOSPITALIZATIONS & SURGERIES
(Include Maternity)

Reasons Hospitalized or Indicate None	Month/Year

List All Serious Injuries or Accidents	Month/Year

Female Only	
Gyn Care Provided by: EFP or	
Pregnancies: #	
Births: #	
Date of Last Pap Smear:	
Date of Last Mammogram	

Please Fill Out Other Side

PERSONAL HISTORY
continued

❑ **Yes** ❑ **No** **Do you now or did you ever smoke: Cigarettes____ Pipe____ Cigars____**
How much per day?____ How many years?____ Quit Date:_____

Caffeine Intake:
Coffee: How Many / Day? _____
Tea: How Many / Day? _____
Soda: How Many / Day? _____
Chocolate: How Many / Day? _____

Alcohol Intake:
Daily: # Per Day _____
Weekly: # Per Week _____
Socially: _____
Rarely: _____
Not At All: _____

Recreational drug use: **Current** ❑ **No** ❑ **Yes** **What type: _____**
Past ❑ **No** ❑ **Yes** **_____**

❑ **Yes** ❑ **No** **Do you wear seat belts?**
❑ **Yes** ❑ **No** **Do you have a routine physical exam?**
❑ **Yes** ❑ **No** **Health care proxy?**

FAMILY HISTORY

Please indicate: Parents, Grandparents, Siblings, Aunts, Uncles
(M) for Maternal (mother's side of the family)
(P) for Paternal (father's side of the family)

(x)	Family Member, Relationship	Illness
		Asthma
		Allergies
		Tuberculosis
		Heart Problem *(please specify)*
		High Blood Pressure
		Diabetes
		High Cholesterol
		Bladder
		Kidney Problem
		Convulsions
		Epilepsy
		Stroke
		Mental Illness
		Thyroid
		Cancer *(please specify)*
		Bleeding Tendency
		Alcoholism
		Family History of Sudden Death