



**DATABASE TOOL**  
**Medical and Personal History**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: M / F Race: \_\_\_\_\_

**For what reason are you here today?** \_\_\_\_\_

**Please check conditions which you have had?**

**GENERAL**

- Serious Infections (e.g. pneumonia) \_\_\_\_\_
- Diabetes Mellitus
- Rheumatic Fever
- HIV Infection
- Cancer (where?) \_\_\_\_\_

**HEENT**

- Glaucoma
- Allergies "hay fever"
- Frequent Ear Infections
- Frequent Sinus Infections

**LYMPHATIC / HEMATOLOGIC**

- Thyroid Goiter
- Over Active Thyroid
- Under Active Thyroid
- Transfusions
- Anemia

- Kidney Stones
- Kidney Failure
- Prostate Disease
- Endometriosis
- Sex Transmitted Infection

**CVS**

- High Blood Pressure
- Congestive Heart Failure
- Heart Murmur
- Heart Valve Disease
- Angina
- Heart Attack
- High Cholesterol
- Abnormal Heart Rhythm
- Blood Clots in Veins
- Blocked Arteries in Neck
- Blocked Arteries in Legs

**RESPIRATORY**

- Asthma
- Emphysema
- Blood Clots in Lungs
- Sleep Apnea

**GI / GU**

- Stomach Ulcers
- Ulcerative Colitis
- Crohns Disease
- Bleeding from Intestines
- Diverticulitis
- Colon Polyps
- Irritable Bowel Disease
- Hepatitis
- Cirrhosis of the Liver
- Liver Failure
- Pancreatitis
- Gallstones

**SKIN / BREAST**

- Acne
- Eczema
- Psoriasis
- Fibrocystic Breast Disease

**MUSCULOSKELETAL / EXTREMITIES**

- Osteoporosis
- Rheumatoid Arthritis
- Degenerative Joint Disease
- Fibromyalgia
- Neck Pain (herniated disc)
- Back Pain (herniated disc)

**NEUROLOGIC / PSYCHIATRIC**

- Chronic Vertigo (Meniere's)
- Peripheral Nerve Disease
- Migraine Headaches
- Stroke
- Multiple Sclerosis
- Depression
- Anxiety

**Doctor's Notes:** \_\_\_\_\_

**Please indicate any surgeries you have had and the year you had them.**

- |                              |                                     |                              |                             |
|------------------------------|-------------------------------------|------------------------------|-----------------------------|
| Year<br>____ Angioplasty     | Year<br>____ Trauma Related Surgery | Year<br>____ Stomach Surgery | Year<br>____ Tubal Ligation |
| ____ Carotid Artery Surgery  | ____ Back or Neck Surgery           | ____ Inguinal Hernia         | ____ C-Section              |
| ____ Other Vascular Surgery  | ____ Hip Surgery                    | ____ Colonoscopy             | ____ Hysterectomy           |
| ____ Coronary Bypass Surgery | ____ Knee Surgery                   | ____ Gallbladder             | ____ Ovary Removed          |
| ____ Chest / Lung Surgery    | ____ Carpal Tunnel Surgery          | ____ Appendectomy            | ____ Breast Surgery         |
| ____ Tonsillectomy           | ____ Sinus Surgery                  | ____ Prostate Surgery        | ____ Thyroid Surgery        |
| ____ Neurosurgery            | ____ Ear Surgery                    | ____ Bladder Surgery         | ____ other _____            |

**Doctor's Notes:** \_\_\_\_\_

**Please indicate when you last had any of the following preventative tests or services.**

- |                                |                          |   |                                      |
|--------------------------------|--------------------------|---|--------------------------------------|
| Year<br>____ Cardiac Angiogram | Year<br>____ Flu Vaccine | Year<br>____ Prostate Cancer Blood Test | Year<br>____ Mammogram / Breast Exam |
| ____ Stress Test               | ____ Pneumonia Vaccine   | ____ Rectal Exam                        | ____ Pap Smear                       |
| ____ Echocardiogram            | ____ Tetanus Vaccine     | ____ Colon Cancer Stool Test            | ____ Date of Last Physical Exam      |
| ____ Chest X-ray               | ____ Hepatitis Vaccine   | ____ Flexible Sigmoidoscopy             | ____ other _____                     |
| ____ EKG                       | ____ Bone Density Test   | ____ Barium Enema                       |                                      |

**Doctor's Notes:** \_\_\_\_\_

Please list any allergies or intolerance to drugs or other substances.

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Please list the medications currently taken, their dosages, and how many times per day you take them.

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**FAMILY MEDICAL HISTORY**

Please check or list any major illness in your family members. (Mother, Father, Brothers, Sisters, or Children)

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|--|--|--|--|
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Breast Cancer   |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Thyroid Disease   | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Ovarian Cancer  |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Anemia            | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Colon Cancer    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hemophilia        | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> _____             | <input type="checkbox"/> _____                 | <input type="checkbox"/> _____           |

Notes:

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**PERSONAL INFORMATION**

Please write in or circle the information that applies to you:

Occupation:

Education	Sexuality	Marital Status	Living Status	Diet	Exercise	Alternative Medicine
primary	heterosexual	single	alone	none	none	holistic
secondary	homosexual	married	with spouse	low fat	walking	chiropractic
college	bisexual	divorced	with parents	low chol	aerobics	homeopathy
post grad	transsexual	widowed	assisted living	low carbo	weightlifting	acupuncture
doctorate		separated	nursing home	vegetarian	___ days / wk	herbal

Tobacco	Alcohol	Illicit Drugs	Caffeine
never / past / active cigarette / cigar / pipe snuff / dip / chewing Start _____ Stop _____ packs per day _____	never / past / active liquor / wine / beer ___drinks per day / week / month AA / Alcohol Rehab	never / past / active cocaine / marijuana heroin / amphetamine barbiturate / LSD / PCP IV Drug Abuse / Drug Rehab	never / past / active coffee / tea / soda ___cans / cups per day

Doctor's Notes:

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