PERSONAL HEALTH HISTORY

JANE R. RELDAN, M.D., INC.

Patient Name: ________________________ DOB: ____________ Today's Date: ___________________________

Updated: ______________________________

1. CHIEF COMPLAINT

2. REVIEW OF SYSTEMS

	Do you currently have....	Yes	No		*Do you currently have....*	Yes	No		*Do you currently have....*	Yes	No
1	Frequent or severe headache			20	Varicose veins			39	Neck pain		
2	Head injury			21	Abdominal pain			40	Back pain		
3	Loss of hearing			22	Hernia			41	Arthritis		
4	Ear pain			23	Heartburn / acid reflux			42	Pain in shoulders, arms, hands		
5	Dizziness			24	Ulcer / frequent antacid use			43	Pain in hips, knees, ankles		
6	Decreased vision or blindness			25	Hemorrhoids			44	Foot pain		
7	Glasses / Contacts			26	Change in bowel habits			45	Anxiety		
8	Eye injury, infection, or pain			27	Constipation			46	Depression		
9	Nose, throat or sinus trouble			28	Diarrhea			47	Suicidal thoughts		
10	Hoarseness			29	Bloody or black stools			48	Epilepsy		
11	Dental / gum disease			30	Weight gain / loss			49	Skin disease / skin cancer		
12	Thyroid disease			31	Hepatitis			50	Cancer		
13	Cough			32	Diabetes			51	Abnormal PAP & treatment		
14	Coughing blood			33	Kidney stones			52	Irregular or painful menstruation		
15	Shortness of breath			34	Bladder infection			53	Date & duration of last period:		
16	Chest pain			35	Bloody urine			54	Date of last PAP:		
17	Palpitations			36	Prostate problems			55	Number of pregnancies:		
18	Swollen ankles			37	Venereal disease / STD			56	Number of living children:		
19	High blood pressure			38	AIDS / HIV			57	Are you currently pregnant?		

Briefly describe any "yes" answer given above. Specify item number.

3. PAST MEDICAL HISTORY: *List all hospitalizations in chronological order from old to new.*

4. SOCIAL HISTORY

58	Living situation:	62	Do you use tobacco?	66	Do you drink alcohol?
59	Occupation:	63	If yes, #________ per day for _____ years	67	BEER: # drinks per week:
60	Do you exercise? Frequency?	64	Do you use recreational drugs?	68	WINE: # drinks per week:
61	Type of exercise?	65	If yes, specify:	69	HARD LIQUOR: # drinks per week:

5. FAMILY HISTORY *(Does any family member currently have, or have they ever had....)*

	Check Each Item	Yes	No		Check Each Item	Yes	No			Age	Alive & Well	Deceased of
70	Allergies			74	Diabetes			78	Mother			
71	Asthma			75	Glaucoma			79	Father			
72	Heart disease			76	Mental illness			80	Children			
73	High blood pressure			77	Cancer			81	Siblings			

6. ALLERGIES *(Medications, Seasonal, Environmental)*

7. CURRENT MEDICATIONS *(List all medications that you currently take, or recently stopped taking)*