Novant Health Medical Group Personal History Review

Name: _____ Phone (H): _____ (W): _____ Date: _____

Address: _____

Date of Birth: _____ Age: _____ M/F/T: _____ Referred by: _____

Reason for visit: _____

Present Medications: _____

Physicians seen in the last 5 years:	Name of MD or other provider	Name of hospital	City and State

PAST MEDICAL HISTORY

Allergies (medication and reaction): _____

List serious illnesses and injuries or operation and approximate year. EXCLUDE NORMAL PREGNANCIES.

Year	Serious Illness, injury, operation	Name of hospital	City and State

Obstetrical: # of pregnancies _____ # of abortions: _____ # of miscarriages: _____ # of living children: _____

Immunizations: ☐ Tetanus _____ Yrs. ago ☐ Rubella ☐ Hepatitis B ☐ Pneumonia

Have you ever had a transfusion? ☐ Yes ☐ No

Check if you have had:

☐ High Blood Pressure	☐ Pneumonia	☐ Colon Polyps	☐ Kidney Stone	☐ Cancer
☐ Heart Attack	☐ Asthma	☐ Diverticulitis	☐ Pelvic Infection	☐ Stroke
☐ Heart Murmur	☐ Emphysema	☐ Hepatitis	☐ Venereal Disease	☐ Convulsion
☐ Heart Failure	☐ Gallstones	☐ Anemia	☐ Tuberculosis	☐ Depression
☐ Diabetes	☐ Stomach Ulcer	☐ Phlebitis	☐ Rheumatic Fever	☐ Arthritis
☐ High Cholesterol	☐ Hiatal Hernia	☐ Thyroid Trouble	☐ Shingles	☐ Alcoholism

FAMILY MEDICAL HISTORY

	MOTHER	FATHER	SIBLING	GRANDPARENT	AUNT / UNCLE	CHILD
High Blood Pressure						
Heart Attack						
High Cholesterol						
Diabetes						
Stroke						
Cancer (type)						
Tuberculosis						
Bleeding Disorder						
Alcoholism						

Mother living? ☐ Yes ☐ No Cause of Death? _____

Father living? ☐ Yes ☐ No Cause of Death? _____

SOCIAL HISTORY

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Significant Other

Number of Children _____ Sons: _____ Daughters _____

Occupation / Prior Jobs _____

Who lives with you? _____

Do you have a living will? ☐ Yes ☐ No Health care power of attorney? ☐ Yes ☐ No

HABITS

Have you ever smoked? ☐ Yes ☐ No How many packs/day? _____ How many yrs? _____ Quit? _____ yrs.

Any other tobacco use? _____ Cups of coffee / caffeinated beverage / day? _____

Do you drink alcohol? ☐ Yes ☐ No How often? _____ How much? _____

Do you exercise? ☐ Yes ☐ No How often? _____ What type? _____

Do you sleep well? ☐ Yes ☐ No How many hours? _____

Do you follow any special diet? ☐ Yes ☐ No What type? _____

Do you wear seatbelts? ☐ Yes ☐ No How often? _____

Do you self Exam? *(breast or testicular)* ☐ Yes ☐ No

Do you regularly use: ☐ Aspirin ☐ Pain Relievers ☐ Laxatives ☐ Cold Preps ☐ Calcium ☐ Vitamins

Are you at risk for HIV infection? ☐ Yes ☐ No

Do you have a history of substance use? ☐ Yes ☐ No What type? _____

Do you have firearms in the house? ☐ Yes ☐ No

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Name / MR # / Label

SYSTEMS REVIEW (TO BE COMPLETED BY PATIENT)

	NOW	PAST YEAR
GENERAL		
FEVER OR CHILLS		
APPETITE CHANGE		
WEIGHT GAIN		
WEIGHT LOSS		
NIGHT SWEATS		
EYES		
BLURRED VISION		
DOUBLE VISION		
CATARACTS		
GLAUCOMA		
EYE PAIN		
ENT		
HEARING LOSS		
FREQUENT EAR PAIN		
RINGING IN EARS		
SINUS TROUBLE		
ALLERGIES OR HAYFEVER		
NOSE BLEEDS		
HOARSENESS		
FREQUENT SORE THROAT		
MOUTH ULCERS		
CARDIOVASCULAR		
HIGH BLOOD PRESSURE		
CHEST PAIN OR TIGHTNESS		
IRREGULAR HEARTBEAT		
FAINTING OR DIZZINESS		
LEG CRAMPS WALKING		
SWOLLEN ANKLES OR FEET		
RESPIRATORY		
BRONCHITIS OR COUGH		
COUGHED BLOOD		
WHEEZING		
SHORTNESS OF BREATH		
GASTROINTESTINAL		
DIFFICULTY SWALLOWING		
HEARTBURN OR INDIGESTION		
ABDOMINAL PAIN		
NAUSEA OR VOMITING		
CONSTIPATION		
DIARRHEA		
RECTAL BLEEDING		
CHANGE IN BOWEL HABIT		
BLACK STOOLS		
VOMITED BLOOD		
YELLOW JAUNDICE		
ENDOCRINE		
FATIGUE		
SENSITIVE TO HEAT OR COLD		
THYROID GOITER OR SWELLING		
CHANGE IN THIRST		
HOT FLASHES		
IMPOTENCE		
DECREASED SEXUAL INTEREST		

	NOW	PAST YEAR
GENITOURINARY		
PAINFUL URINATION		
FREQUENT URINATION		
SLOW STREAM		
URINATION AT NIGHT		
BLADDER CONTROL PROBLEM		
BLOOD IN URINE		
URINARY INFECTION		
KIDNEY STONES		
VENEREAL DISEASE		
TESTICLE SWELLING OR PAIN		
VAGINAL DISCHARGE		
PAINFUL MENSTRUAL PERIODS		
IRREGULAR VAGINAL BLEEDING		
PAINFUL INTERCOURSE		
VAGINAL DRYNESS		
MUSCULOSKELETAL		
JOINT PAIN		
BACK OR NECK PAIN		
ARM OR LEG PAIN		
MUSCLE PAIN OR CRAMPS		
SKIN / BREASTS		
DRY SKIN		
RASHES		
CHANGE IN MOLES OR GROWTHS		
PERSISTENT ITCHING		
SORE THAT DOES NOT HEAL		
HAIR LOSS		
BREAST LUMPS		
BREAST TENDERNESS OR PAIN		
NIPPLE DISCHARGE		
NEUROLOGICAL		
FREQUENT HEADACHES		
MIGRAINE HEADACHES		
NUMBNESS OF ARMS OR LEGS		
MUSCLE WEAKNESS		
POOR COORDINATION		
FALLS		
TREMOR OR SHAKING		
TROUBLE SLEEPING		
PSYCHIATRIC		
DEPRESSION		
ANXIETY		
MEMORY CHANGE		
COUNSELING OR TREATMENT		
HEMATOLOGIC / LYMPHATIC		
SWOLLEN GLANDS		
EASY BRUISING OR BLEEDING		
ALLERGIC / IMMUNOLOGIC		
RASHES		
DRUG REACTIONS		

REVIEWED BY PROVIDER: _____ DATE _____ TIME _____

PATIENT SIGNATURE: _____ DATE _____ TIME _____

Name / MR # / Label