

Patient History Review Form

Dr. Anne Rose N Eapon, M.D.

Name _____ Age _____ Single or Married _____ Divorced or Widow(er) _____ Date _____

Occupation _____ All previous occupations _____ Birth Place _____

Education: _____ years High School _____ years College _____ years Post Graduate _____

Please list all Symptoms, and use this space for any comments or questions you have for the doctor:

Family History	If Living		If Deceased		Has any blood relative ever had:	who
	Age	Health	Age at death	Cause		
Father					Cancer	no yes
Mother					Diabetes	no yes
Brother or Sister	1.				Heart trouble	no yes
	2.				Hypertension	no yes
	3.				High Cholesterol	no yes
	4.				Stroke	no yes
Son or Daughter	1.				Mental Illness/Suicide	no yes
	2.				Other:	
	3.					
	4.					
				no yes		

PERSONAL HISTORY

Immunization or Infection if vaccinated, yr.

Chicken Pox no yes _____

Measles/Mumps/Rubella (MMR) no yes _____

Hepatitis B no yes _____

Pneumovax no yes _____

dT no yes _____

Skin test for tuberculosis pos neg yr. _____

WEIGHT: Now: _____ One year ago _____

Max. _____ When? _____

Any intentional weight loss _____ no yes

When? _____

TRANSFUSIONS: Have you ever had

Blood or Plasma transfusion _____ no yes

SURGERY: Have you had

Tonsillectomy _____ no yes

Appendectomy _____ no yes

List other surgeries and the dates:

Have you been hospitalized for any other illness _____ no yes

Give details:

ILLNESSES: Have you ever had-

(please circle answer for each question)

Rheumatic fever	no	yes
Pneumonia	no	yes
Influenza	no	yes
Pleurisy	no	yes
Heart disease	no	yes
Arthritis or Rheumatism	no	yes
Any bone or joint disease	no	yes
Neuritis or neuralgia	no	yes
Bursitis, Sciatica or Lumbago	no	yes
Meningitis	no	yes
Gonorrhea or Syphilis	no	yes
Herpes or Genital Warts	no	yes
Anemia	no	yes
Jaundice or Hepatitis	no	yes
Epilepsy	no	yes
Migraine headaches	no	yes
Tuberculosis	no	yes
Diabetes	no	yes
Cancer	no	yes
High or low blood pressure	no	yes
High cholesterol	no	yes
Nervous breakdown	no	yes
Food, chemical or drug poisoning	no	yes
Hay fever or Asthma	no	yes
Hives or Eczema	no	yes
Frequent infections or boils	no	yes
Frequent colds or sore throat	no	yes
Any other disease	no	yes

ALLERGIES: Are you allergic to

Penicillin or Sulfa	no	yes
Aspirin, Codeine or Morphine	no	yes
Mycins or other antibiotics	no	yes
Any other drug	no	yes
Any foods (including eggs)	no	yes
Adhesive tape	no	yes
Tetanus Antitoxin or Serums	no	yes

NOTE: This is a confidential record of your medical history and will be kept in this office. Information obtained here will not be released to any person except

CXR: When was your last chest x-ray _____

X-RAYS: Any other? Please specify _____

EKG: When was your last electrocardiogram _____

FLEXIBLE SIGMOIDOSCOPY OR COLONOSCOPY: Have you had one, and when _____

INJURIES: Have you had any
Broken or cracked bones/Dislocationsno yes
Sprainsno yes
Concussion or head injuryno yes
Knocked unconsciousno yes
Have you ever experienced physical or sexual abuseno yes

SYSTEMS: Do you have or have you ever had:
Any eye disease, injury, impaired sightno yes
Any ear disease, injury, impaired hearingno yes
Any trouble with nose, sinuses, mouth throatno yes
Loss of consciousness/Fainting Spellsno yes
Convulsionsno yes
Paralysisno yes
Dizzinessno yes
Frequent or severe headachesno yes
Depression or anxietyno yes
Hallucinationsno yes
Enlarged glands or lumpsno yes
Enlarged thyroid or goiterno yes
Skin changes or changes in molesno yes
Chronic or frequent coughno yes
Chest pain or chest pressureno yes
Spitting up of bloodno yes
Night sweatsno yes
Shortness of breathno yes
Palpitation or fluttering heartno yes
Swelling of hands, feet or anklesno yes
Varicose veinsno yes
Extreme tiredness or weaknessno yes
Kidney disease or stonesno yes
Bladder diseaseno yes
Albumin, sugar, pus, etc. in urineno yes
Difficulty in urinatingno yes
Abnormal thirstno yes
Stomach trouble or ulcerno yes
Indigestionno yes
Liver or gall bladder diseaseno yes
Jaundice or hepatitisno yes
Colitis or other bowel diseaseno yes
Hemorrhoids or rectal bleedingno yes
Constipation or diarrheano yes
Has there been any recent change in:
Your appetite or eating habitsno yes
Your bowel action or stoolsno yes
Any unintentional weight lossno yes
Aching or swelling muscles or jointsno yes

HABITS:
Exercise adequatelyno yes
How?

Sleep wellno yes
Average hours of sleep _____
Bowels move regularly?no yes
Diet well balanced?no yes
Salt use: light moderate much
Milk: _____ cups (8 ounces per cup) per day
Caffeinated beverages: _____ cups per day - kind _____
Water: _____ cups per day

Alcoholic beverages:
Amount _____ Frequency _____ Type _____
Have you been treated for alcoholism?no yes
Have you used tobaccono yes
How long? _____ When stopped? _____
How much per day? _____
Type: Cigarettes Cigars Pipe Snuff Chewing tobacco
Any history of recreational drug use?no yes

DRUGS: Check frequency of use
Laxatives never occ freq daily
Vitamins never occ freq daily
Tranquilizers/Sedatives: never occ freq daily
Sleeping pills: never occ freq daily
Cortisone, Acth, Prednisone never occ freq daily
Aspirin: never occ freq daily
Thyroid: never occ freq daily
Appetite Depressants: never occ freq daily
Have you ever taken insulin or oral agents for diabetes?no yes
Have you ever taken hormone shots or tablets?no yes

List all medications, vitamins or supplements you are now taking including over-the-counter medications, and include amount and frequency:

Sex: abstinent active ; satisfactory unsatisfactory
Sexual orientation: Heterosexual Homosexual Bisexual
Work: _____ hours/day - indoors outdoors
Do you like your work?no yes
Recreation:
Do you participate in sports or have any hobbies which give you relaxation at least 3 hrs/wkno yes
TV _____ hrs/day
Reading _____ hrs/week
Vacations _____ weeks/year

HIV RISK:
Have you been intimate with prostitutes or IV drug abusers?no yes
Have you had more than one sexual partner in the last year?no yes
In the last 5 years?no yes
Have you or your sexual partner had ANY transfusions between 1978 and 1985?no yes
What other physicians or specialists do you see? _____

WOMEN ONLY:
Menstrual History: Age at onset _____ Regular - yes no
Cycle: _____ days from start to start
Usual duration: _____ days Heavy Medium Light
Pains or cramps: yes no
Date of last period: _____ Date of last pap smear: _____
Date of last mammogram: _____
Breast lumps, tenderness or discharge?no yes
Age at onset of menopause _____ if applicable
Pregnancies
How many? _____
How many born living? _____
Any complications with any pregnancy?no yes
Your age at which first child was born _____