CHI Health Clinic

PERSONAL HISTORY

Clinic Name	For Internal Use Only Medical Record Number

Full Name	Preferred Name/Nickname	Birth Date	Today's Date

Personal Medical History (Check if you presently have or have had any of the following)

- ☐ Headache
- ☐ High blood pressure
- ☐ Stroke
- ☐ Phlebitis (blood clots)
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Chest pain
- ☐ Heart palpitations (irregular heart beat)
- ☐ Heart murmur
- ☐ High cholesterol
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Diabetes
- ☐ Anemia
- ☐ Allergies/hay fever/ chronic sinusitis
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic diarrhea
- ☐ Constipation
- ☐ Nervous stomach
- ☐ Hepatitis
- ☐ Gallbladder disease
- ☐ Low back pain
- ☐ Arthritis
- ☐ Gout
- ☐ Thyroid disease
- ☐ Dizziness/fainting
- ☐ Seizures/convulsions
- ☐ Alcoholism
- ☐ Depression
- ☐ Nervousness/anxiety
- ☐ Psychiatric disorder
- ☐ Osteoporosis
- ☐ Menstrual disorder
- ☐ Incontinence
- ☐ Prostate disease
- ☐ Sexually transmitted disease
- ☐ Frequent infections
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ Chronic rashes
- ☐ Glaucoma
- ☐ Other – Describe:
- ☐ Other – Describe:

Current Medications: (Include vitamins/ supplements) (continued on back)

Drug Allergies **(continued on back)**

Environmental Allergies (such as latex, pollen, foods) (continued on back)

Do you have a living will? ☐ Yes ☐ No

WOMEN ONLY:

Pregnant ☐ Yes ☐ No

Planning Pregnancy ☐ Yes ☐ No

Using Birth Control ☐ Yes ☐ No

Method: _____

Number of Pregnancies/Births /

Hospitalizations and Major Surgeries (continued on back)

Reason	Year/Age	Reason	Year/Age

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Other	Describe
Heart Disease	☐	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	
Migraine Headache	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Other	Describe
Mental Illness	☐	☐	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	☐	☐	
Bleeding Disorder	☐	☐	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	☐	☐	
Epilepsy/ Seizures	☐	☐	☐	☐	☐	☐	
Other: Describe:	☐	☐	☐	☐	☐	☐	
Other: Describe:	☐	☐	☐	☐	☐	☐	
Other: Describe:	☐	☐	☐	☐	☐	☐	

Habits

	How much/How Long			Describe
☐ Tobacco		☐ Caffeine		☐ Sleep problems
☐ Alcohol		☐ Street drugs		

Please list year of last:

Chest x-ray	Mammogram	EKG
Pap smear	Tetanus shot	Cholesterol

Physician Review	Date	Date	Date	Date	Date	Date	Date	Date

Current Medications: (Include vitamins/ Supplements)	

Drug Allergies

Environmental Allergies (such as latex, pollen, foods)

Hospitalizations and Major Surgeries			
Reason	**Year/Age**	**Reason**	**Year/Age**