Name:_____ Date:_____

PERSONAL HISTORY FORM

Do you have or have you had any of the following medical conditions?
(Circle the correct answer)

	Yes	No	Don't know
General			
Difficulty sleeping	Y	N	?
Change in weight	Y	N	?
Cancer	Y	N	?
Skin			
Poor healing	Y	N	?
Easy bruising	Y	N	?
Leg wounds	Y	N	?
Eyes, Ears, Nose, Throat			
Decreased hearing	Y	N	?
Blurred vision	Y	N	?
Swallowing trouble	Y	N	?
Nose bleeds	Y	N	?
Endocrine			
Diabetes	Y	N	?
Thyroid problems	Y	N	?
Lungs			
Short of breath	Y	N	?
Cough	Y	N	?
Asthma	Y	N	?
Emphysema	Y	N	?
Blood clots in lung	Y	N	?
Heart			
Chest pain	Y	N	?
High cholesterol	Y	N	?
High blood pressure	Y	N	?
Irregular heart beat	Y	N	?
Pacemaker	Y	N	?
Heart attack	Y	N	?
Cogestive heart failure	Y	N	?
Gastro-intestinal			
Abdominal pain	Y	N	?
Stomach ulcer	Y	N	?
Gallstones	Y	N	?
Hepatitis	Y	N	?
Nutrition problems	Y	N	?

	Yes	No	Don't know
Kidneys and Bladder			
Kidney disease	Y	N	?
Kidney stones	Y	N	?
Renal failure	Y	N	?
Dialysis	Y	N	?
Bladder problems	Y	N	?
Bloody urine	Y	N	?
Urinary infections	Y	N	?
Gynecologic			
Are you pregnant	Y	N	?
Menstrual problems	Y	N	?
Neurologic			
Numbness	Y	N	?
Stroke	Y	N	?
Mini-stroke	Y	N	?
Headaches	Y	N	?
Seizures	Y	N	?
Light-headed	Y	N	?
Musculo-skeletal			
Back pain	Y	N	?
Arthritis	Y	N	?
Leg cramps	Y	N	?
Vascular			
Blood clots in legs	Y	N	?
Circulation problems	Y	N	?
Varicose veins	Y	N	?
Hardening of arteries	Y	N	?
Phlebitis	Y	N	?
Pain with walking	Y	N	?
Psychologic			
Stress	Y	N	?
Anxiety	Y	N	?
Depression	Y	N	?
Coagulation			
Clotting problems	Y	N	?
Bleeding problems	Y	N	?

Other problems:

Reviewed: Y or N **Agree/Edited: Y or N** **Signature:**_____