Genitourinary (Women): ☐ *None apply*

☐Frequent urination (often at night) ☐Frequent urge to pee ☐Pain on urination ☐Bloody urine ☐Frequent urinary infections

☐Pressure in vagina ☐Vaginal wall weakness/protrusion ☐Frequent loss of urine

☐Vaginal discharge ☐Vaginal irritation ☐Vaginal dryness ☐Vaginal redness ☐Vaginal pain

☐Painful intercourse ☐Decline in sexual desire ☐Difficulty in sexual response

☐Hot flashes ☐Change in periods (menstrual flow, frequency)

☐Painful periods ☐Troublesome symptoms before/during periods ☐Other pelvic pain

Please indicate:

Number of pregnancies _____ Number of deliveries _____ Number of miscarriages/abortions _____

Age at onset of periods _____ Periods occur every _____ days and last _____ Onset of last period _____

Comment: _____

Lymphatic/Hematologic: ☐ *None apply*

☐Unusual lymph node swelling (in neck, arm pit, or groin) ☐Painful lymph nodes

☐History of anemia ☐Bloody clots ☐Bruise easily ☐Unusual bleeding

Comment: _____

Musculoskeletal: ☐ *None apply*

☐Limb or joint pains ☐Limb or joint deformity ☐Limb or joint swelling/stiffness/redness

☐Muscle weakness ☐Loss of muscle bulk ☐Muscle spasms or twitching

☐Recurring back/neck pain ☐Back/neck injury

Comment: _____

Neurologic: ☐ *None apply*

☐Seizures ☐Tremors/shakiness ☐Unusual clumsiness ☐Limb weakness ☐Numbness/tingling ☐Stroke

☐History of significant head injury ☐Altered consciousness or black-outs

Comment: _____

Psychologic: ☐ *None apply*

☐Lapses in memory ☐Periods of confusion/disorientation ☐Difficulty concentrating

☐Troublesome depression ☐Worry about things ☐Mood swings ☐History of mental illness

☐Unusual stress ☐History of physical or mental abuse

Comment: _____

Skin: ☐ *None apply*

☐Itching ☐Rash ☐Unusual dryness ☐Changes in hair ☐Changes in pigmentation

Comment: _____

Endocrine: ☐ *None apply*

Unexpected changes in: ☐Tolerance to heat ☐Tolerance to cold ☐Unusual thirst

Comment: _____

Allergy/Immunologic: ☐ *None apply*

☐Seasonal allergies ☐Sensitivity to specific items: _____

Comment: _____

SENTARA®

PATIENT PERSONAL HISTORY FORM

Please take time to update the following information for our files. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs.

NAME	BIRTH DATE	DATE

CHIEF COMPLAINTS: *(Please list current symptoms)*

1.	3.
2.	4.

PAST MEDICAL HISTORY: *Hospitalizations and Surgeries*

Reason/Diagnosis/Procedure	Date	Reason/Diagnosis/Procedure	Date

MEDICAL ILLNESSES OR CONDITIONS: *(Conditions you now have or have had in the past.)*

CONDITION	ONSET DATE	CONDITION	ONSET DATE	CONDITION	ONSET DATE
☐ Migraine headaches	_____	☐ Stomach or duodenal ulcer	_____	☐ Goiter	_____
☐ Seizures or convulsions	_____	☐ Hepatitis	_____	☐ Gonorrhea	_____
☐ Stroke	_____	☐ Cirrhosis	_____	☐ Syphilis or VD	_____
☐ Polio	_____	☐ Gall stones	_____	☐ HIV infection	_____
☐ Glaucoma	_____	☐ Colon or bowel trouble	_____	☐ Herpes infection	_____
☐ Cataracts	_____	☐ Dysentery or serious diarrhea	_____	☐ Chicken pox	_____
☐ Blindness	_____	☐ Rectal trouble	_____	☐ Mumps	_____
☐ Recurrent ear infections	_____	☐ Hemorrhoids	_____	☐ Measles	_____
☐ Deafness	_____	☐ Recurrent urinary infections	_____	☐ Recurrent boils	_____
☐ Hay fever, allergic nose	_____	☐ Kidney stones	_____	☐ Skin problems	_____
☐ Recurrent sinusitis	_____	☐ Other kidney disease	_____	☐ Serious depression	_____
☐ Asthma	_____	☐ Arthritis	_____	☐ Serious emotional problems	_____
☐ Chronic Bronchitis	_____	☐ Gout	_____	☐ Nervous breakdown	_____
☐ Emphysema	_____	☐ Broken bones	_____	☐ Other _____	
☐ Tuberculosis	_____	☐ Varicose veins	_____		
☐ Heart murmur	_____	☐ Phlebitis or blood clots	_____	☐Other _____	
☐ Heart attack	_____	☐ Bleeding problems	_____		
☐ Angina	_____	☐ Anemia	_____	*Women*	
☐ Enlarged heart	_____	☐ Cancer (Type:_____)	_____	☐ Menstrual difficulties	
☐ Rheumatic fever	_____	☐ Diabetes	_____	☐ Ovarian cyst(s)	
☐ High blood pressure	_____	☐ Overactive thyroid	_____	☐ Breast lump(s)	
☐ Hiatal hernia/chronic heartburn	_____	☐ Underactive thyroid	_____	*Men*	
				☐ Prostate trouble	

CURRENT MEDICATIONS: *(Include non-prescription products)*		**Allergies:** *(Include drugs, foods, chemicals, insects, etc.)*	
Drug Name	Dose	Item	Type of Reaction

IMMUNIZATIONS & PREVENTIVE SERVICES: *(Check all that apply and provide date you last received each.)*

☐ MMR	_____	☐ TB skin test	_____	☐ Pap Smear	_____
☐ Tetanus	_____	☐ Hearing test	_____	☐ Mammogram	_____
☐ Pneumonia vaccine	_____	☐ Eye exam	_____	☐ Bone Density test	_____
☐ Hepatitis B vaccine	_____	☐ Sigmoid or Colon exam	_____	☐ PSA	_____

FAMILY HISTORY: *Please complete the following information on your relatives.*

	Living	Dead	Age	Chronic Condition(s)/Cause of Death
Father				
Mother				
Brothers (No. __) & Sisters (No. __)				
Spouse				
Children (No. ____)				

Please check all conditions identified in your relatives and note which relatives are affected:

Condition	Relation	Condition	Relation	Condition	Relation
☐ Migraine headaches	_____	☐ High blood pressure	_____	☐ Bleeding problems	_____
☐ Seizures or convulsions	_____	☐ Stomach or duodenal ulcer	_____	☐ Anemia	_____
☐ Stroke	_____	☐ Liver disease	_____	☐ Sickle cell disease	_____
☐ Glaucoma	_____	☐ Gall stones	_____	☐ Cancer, including leukemia	_____
☐ Allergies	_____	☐ Colon or bowel trouble	_____	☐ Diabetes	_____
☐ Asthma	_____	☐ Kidney stones	_____	☐ Thyroid problems	_____
☐ Emphysema	_____	☐ Other kidney disease	_____	☐ Mental Illness	_____
☐ Tuberculosis	_____	☐ Arthritis	_____	☐ Suicide	_____
☐ Heart trouble	_____	☐ Gout	_____	☐ Birth defects	_____

SOCIAL/PERSONAL HISTORY: *Please complete the following information on yourself.*

Current occupation: _____

Education completed:

☐ Grade: _____ ☐ High School: _____ ☐ College: _____years, degree/major_____ ☐Post-graduate: _____

Marital status: ☐ Single ☐ Married (Date: _____) ☐ Separated (Date: _____) ☐ Divorce (Date: _____)
☐ Widowed (Date: _____)

Married _____ time(s): #1:_____ yrs, _____ children #2:_____ yrs, _____ children #3:_____ yrs, _____ children

Personal habits: *(check all that apply)*

☐ Currently use tobacco: Type: ☐Cigarettes ☐Cigars ☐Pipe ☐Smokeless tobacco Amount/day: _____ Years: _____

☐ Former smoker: Amount/day: _____ Years: _____ Quit Date: _____

☐ Exposed to second-hand smoke

☐ Consume alcohol: Type: _____ Amount/day: _____

☐ Use recreational drugs: Type: _____ Frequency: _____

☐ Consume caffeine: Beverage: _____ Amount/day: _____

☐ Exercise regularly: Type: _____ Frequency/week: _____

☐ Wear my seatbelt: Frequency (%): _____

Sexual history: ☐Multiple Sex Partners ☐Prefer Opposite Sex ☐Prefer same-sex relationships

Name: _____ Birthdate: _____ Date: _____

REVIEW OF SYSTEMS: *(Please check any item which describes recent or ongoing symptoms.)*

General: ☐*None apply*

☐Significant weight loss ☐Loss of well-being ☐ Fatigue or loss of energy ☐Difficulty sleeping

Comment: _____

Eyes: ☐*None apply*

☐Blurred vision ☐Double vision ☐Spots in front of your eyes ☐Eye pain/irritation ☐Need for corrective lenses

Comment: _____

Ear-Nose-Throat: ☐ *None apply*

☐Chronic headaches ☐Hearing loss ☐Ringing in ears ☐Dizziness

☐Chronic nasal congestion ☐Recurring sinus infections ☐Nose bleeds ☐Nasal obstruction

☐Bleeding gums ☐Sore throat ☐Toothache

☐Breath odor ☐Hoarseness

Comment: _____

Respiratory: ☐ *None apply*

☐Shortness of breath ☐Cough ☐Chest congestion ☐Wheezing

☐Coughing up blood ☐Choking ☐Noisy breathing

☐History of pneumonia ☐History of Tuberculosis (TB)

Comment: _____

Cardiovascular: ☐ *None apply*

☐Chest pain ☐Heart fluttering/racing ☐ Heart murmur ☐Decreased exercise tolerance

☐Awakening due to shortness of breath ☐ Difficulty breathing when lying down ☐Leg swelling

☐Pain in buttocks or legs with exercise ☐Sensitivity of hands/feet to temperature changes

Comment: _____

Breast: ☐*None apply*

☐Breast lump ☐Breast pain ☐Nipple discharge

Comment: _____

Gastrointestinal: ☐*None apply*

☐Stomach pains ☐Nausea ☐ Vomiting ☐ Diarrhea ☐Constipation

☐Frequent heartburn ☐Indigestion ☐Belching/sour taste ☐Difficulty swallowing ☐Bloating

☐History of hepatitis ☐ History of yellow jaundice

Rectal:

☐Rectal bleeding ☐Rectal pain or irritation ☐Swelling or hemorrhoids

Comment: _____

Genitourinary (Men): ☐*None apply*

☐Frequent urination (☐often at night) ☐Frequent urge to pee ☐Pain on urination ☐Bloody urine ☐Discharge from penis

☐Trouble starting urination ☐ Interruption of urine stream ☐ Dribbling ☐ Loss of bladder control ☐ Bloating

☐Pain or swelling of penis ☐Pain or swelling of scrotal sac ☐Pain or swelling in groin

☐Decline in sexual desire ☐ Difficulty having erections or reaching climax

Comment: _____

#1399 (05/2017)