1101 East High St., Upper Level
Charlottesville, VA 22902
Telephone (434) 296-9596 Fax (434) 296-9196

Self History Form

Name:________________________________Birth Date:________________Age:______Date:_______________

Family Physician:____________________________Social Security Number:_____________________________

Past History: Have you ever had any of the following illnesses?

Arthritis Yes ☐ No ☐	Cancer Yes ☐ No ☐	Diabetes Yes ☐ No ☐	Heart Attack Yes ☐ No ☐
High Blood Pressure Yes ☐ No ☐	Kidney Disease Yes ☐ No ☐	Hiatal Hernia, Ulcer, or gastritis Yes ☐ No ☐	High Cholesterol Yes ☐ No ☐
Lung Disease Yes ☐ No ☐	Stroke Yes ☐ No ☐	Seizure Yes ☐ No ☐	Thyroid Disease Yes ☐ No ☐

Were you ever hospitalized for operations, illness, injury, or childbirth?

Year/How long ago?	Reason	Hospital	Doctor

Medications: List current medications and dosage including Aspirin:

Medication	Dose	Frequency	Medication	Dose	Frequency

Allergies: Allergy to any drug____

X-Ray Dye_______________________________Iodine___________________Shellfish___________________

Patient Name:____Date:________________________

Habits: Do you smoke? Yes No How much?________________________

Past Smoking History Yes No How much?________________When stopped?_______

Do you drink alcoholic beverages? Yes No How much?________________________

Do you exercise? Yes No How often?________________________

Occupation:____

Are you retired?_______________Are you now disabled?____________________________

Family History: Has any member of your family (parents, brothers, sisters, aunts or uncles) had any of the following? (Please state who in the family)

Heart Disease or heart attack:____

High Blood pressure:____

Diabetes:____

Sudden Death:____

	IF LIVING		IF DECEASED	
	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHER 1				
BROTHER 2				
BROTHER 3				
SISTER 1				
SISTER 2				
SISTER 3				
SPOUSE				
CHILDREN 1				
CHILDREN 2				
CHILDREN 3				
CHILDREN 4				

Patient Name:____ Date:_______________________________

Do you now have or have you had within the past year:

	Yes	No		Yes	No
Headaches			**Leg Cramps**		
Fainting with loss of consciousness			**Walking**		
Dizziness or lightheadedness			**At Night**		
Vertigo			**Ankle Swelling**		
Glasses/Contacts			**Arthritis**		
Blurred Vision			**Joints Affected_______________**		
Double Vision			**Varicose Veins**		
Glaucoma			**Blood Clot in Legs (phlebitis)**		
Decrease in hearing			**Chest Pain or Pressure**		
Earaches			**With exercise**		
Ringing in Ears			**At Rest**		
Sinus Trouble			**How often?______________**		
Persistent Hoarseness			**Pain in Arms**		
Enlarged Glands			**Palpitations or fluttering of heart**		
Nosebleeds			**Heart murmur**		
Do you wear Dentures?			**Rheumatic Fever**		
Any soreness or bleeding of gums?			**Shortness of Breath**		
Heartburn/indigestion			**Walking**		
Loss of appetite			**How many blocks___________**		
Weight change			**One flight of stairs**		
Nausea/Vomiting			**On lying down**		
Constipation			**Wake up at night short of breath**		
Diarrhea			**Chronic or frequent cough**		
Blood in Stool			**Any blood in sputum**		
Gallbladder disease					
Colitis/diverticulitis			**Women ONLY—Menstrual History**		
Difficulty swallowing			**Last Menstrual Period ____________**		
Stomach Ulcer			**Any abnormal bleeding or spotting**		
Pain on Urination			**Any menopausal symptoms**		
Do you get up at night to urinate			**Pregnancies**		
How many times?___________			**How many children born alive_________**		
Urgency			**How many still births_________________**		
Inability to tolerate cold			**How many miscarriages______________**		
Inability to tolerate heat			**How much weight did you gain_________**		
Hot flashes or flushing			**Swelling of hands, feet or ankles after exercise**		
Skin Rashes			**Any complications with pregnancy**		
Easily Fatigued					