Expresscare Plus
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PERSONAL HISTORY

Name _____ DOB _____ Date _____

❑ Male ❑ Female Occupation _____

Insert an X by problems you've had.

ILLNESS
_____ measles
_____ mumps
_____ german measles
_____ chickenpox
_____ rheumatic fever
_____ tuberculosis
_____ infectious mono
_____• cancer
_____ diabetes
_____ thyroid disease
_____ bleeding disorders
_____• anemia
_____• migraines
_____ eye disorders
_____ hearing problems
_____• fainting
_____ frequent sinusitis
_____• frequent nosebleeds
_____ asthma
_____ pneumonia
_____ frequent bronchitis
_____ emphysema
_____ chronic cough
_____• chest pain
_____ arthritis
_____• gout
_____ heart disease
_____ heart murmur
_____ circulation problems
_____ palpitation
_____ high blood pressure
_____ high cholesterol
_____• swelling
_____ stomach problems
_____ ulcers
_____ colitus
_____ hemorrhoids
_____ liver disease
_____ hepatitis
_____• hernia
_____ bladder infection
_____ kidney disease
_____• kidney stones
_____ nervous disorders
_____ convulsions
_____ other _____
_____ other _____

YEAR SURGERIES
_____ tonsils
_____ appendix
_____ hernia
_____ gallbladder
_____ bladder surgery
_____ hemorrhoids
_____ fracture repair
_____ back surgery
_____ other _____
_____ other _____

YEAR ACCIDENT
_____ whiplash
_____ concussion
_____ burns
_____ lacerations
_____ fractures
_____ back injury
_____ other _____
_____ other _____

ALLERGIES
_____ hay fever
_____ asthma
_____ foods _____
_____ animals _____
_____ iodine
_____ penicillin
_____ aspirin
_____ codeine
_____ sulfa
_____ other _____

MEDICATIONS
(taken routinely)
_____ aspirin
_____ birth control pill
_____ hormones
_____ antacids
_____ laxatives
_____ digitalis
_____ high blood pressure
_____ water pills
_____ blood thinners
_____ insulin
_____ diabetes medication
_____ anticonvulsants
_____ sleeping pills
_____ tranquilizers
_____ diet pills
_____ thyroid

IMMUNIZATIONS
YEAR OF LAST
_____ dpt
_____ polio
_____ measles
_____ mumps
_____ german measles
_____ tetanus
_____ flu
_____ tb
_____ hib
_____ hepatitis

HABITS PER DAY
_____ cigarettes _____ packs
_____ cigars _____ number
_____ pipe _____ number
_____ beer _____ bottles/cans
_____ alcohol _____ shots
_____ coffee _____ cups
_____ tea _____ cups
_____ pop _____ cans/bottles

DATE MEN ONLY
_____ prostate exam
_____ prostate blood test

DATE WOMEN ONLY
_____ last pap smear
_____ mammogram
_____ hysterectomy
_____ tubal ligation
_____ breast biopsy
_____ d&c

PREGNANCIES
_____ full term
_____ premature
_____ miscarriage
_____ living

FAMILY HISTORY
Insert X where appropriate.

	Age	Good Health	Poor Health	Heart Dis.	High B.P.	Stroke	Kidney Dis.	Bleeding Dis.	Ulcer	Colitis	Arthritis	Diabetes	Thyroid Dis.	Cancer	Cause of death
Father															
Mother															
Brother or Sister, Insert B or S															
Brother or Sister, Insert B or S															
Brother or Sister, Insert B or S															
Brother or Sister, Insert B or S															