The Greenbrier Clinic, Inc.

White Sulphur Springs, West Virginia
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PERSONAL DATA FORM

Instructions: Your health is very important to us. Please make every effort to complete this form carefully. The more thorough you are, the better health care you will receive and the easier it will be to optimally code your examination for insurance purposes. CONFIDENTIAL: Information contained here will not be released except when authorized by the patient.

☐ Yes ☐ No Is one of your reasons for coming to the Clinic to have a "complete physical"–a detailed preventive medicine examination including assessment of risk factors and screening tests appropriate for your age, sex, family history and state of health?

LAST NAME	FIRST	MIDDLE	BIRTH DATE	AGE	BIRTH PLACE

ADDRESS	CITY	STATE	ZIP	HOME PHONE	BUSINESS PHONE

OCCUPATION	MEDICARE#	MEDICAID #	SEX	MARITAL STATUS

INSURANCE COMPANY	INSURANCE #	M	F	M	S	W	D	SEPARATED

Person to Notify: _____ Relationship: _____

Address: _____ Phone #: _____

Family Physician: _____ Address: _____

Were you referred to The Clinic by someone?_____ If so, who? _____

If referred by a doctor, give name and address: _____

_____

CHIEF MEDICAL CONCERNS: List briefly the medical concerns on which you would like us to concentrate:

PAST MEDICAL HISTORY

Childhood Illnesses: _____

Surgery: (Type and year of any operation which you have had): _____

_____

_____

PAST MEDICAL HISTORY–(Continued)

Hospitalizations for other reasons (not requiring surgery): _____

_____

_____

Other Medical Conditions (including hypertension, diabetes, low thyroid, ulcer, emphysema, etc.): _____

_____

Serious Accidents or Injuries (including broken bones): _____

Transfusions: (with dates): _____

Immunizations: (most recent year):

INFLUENZA _____ TETANUS _____ PNEUMOVAX _____

OTHER: _____ HEPATITIS A _____ HEPATITIS B _____

MEDICATIONS (LIST ALL PRESCRIPTION AND NON-PRESCRIPTION DRUGS, VITAMINS, SUPPLEMENTS, AND INCLUDE DOSAGE AND FREQUENCY):

_____

_____

_____

_____

_____

DRUG ALLERGIES & ENVIRONMENTAL ALLERGENS? _____

_____

FAMILY HISTORY:		If Living		If Deceased	
		Age	Health Problems	Age at Death	Cause of Death
Father					
Mother					
Brothers/Sisters (circle sex)					
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					

CHILDREN: List number and ages: _____

Do you know any blood relative who has or had: (Circle and give relationship):

Diabetes _____ Alzheimer's Disease _____

High Cholesterol _____ Heart Attack _____

Psychiatric disorder _____ Osteoporosis _____

Congestive heart failure _____ Heart surgery _____

Stroke _____ Heart failure _____

Thyroid disease _____ Gout _____

Kidney disease _____ Glaucoma _____

Hypertension _____

Tuberculosis _____

Cancer _____

Other Hereditary diseases _____

TOXIN EXPOSURE (asbestos, coal dust, chemicals, radiation, etc.) _____

MILITARY SERVICE (DATE) _____

INJURIES/DISABILITIES: _____

HIGHEST LEVEL OF EDUCATION: _____

RECENT FOREIGN TRAVEL? _____

HABITS AND SOCIAL HISTORY

Alcohol: Average number of drinks per (circle) day/week
_____liquor _____wine _____beer

Tobacco: Ever smoke cigarettes regularly? _____yes _____no
Do you smoke now? _____yes _____no
How many packs per day? _____
How many years?_____
Do you smoke a pipe or cigar? _____yes _____no
Do you chew tobacco or use snuff? _____yes _____no
If QUIT, what year?_____

Caffeine: Average number of drinks daily
_____reg. coffee _____decaf _____tea
_____caffeinated soft drinks

Sleep: Difficulty falling asleep? _____yes _____no
Describe _____
Awaken at night with difficulty getting back to sleep? _____yes _____no
Hours of sleep per night _____ Get enough sleep overall? _____yes _____no

Exercise: Do you get regular exercise? _____yes _____no
Describe: _____
If you are a hotel guest, would you like help starting a program? _____yes _____no

Diet: Do you eat fruits and vegetables daily? _____yes _____no
Sweets (desserts, snacks, candy)_____low_____moderate_____high
Salt (added or in foods, snacks) _____low_____moderate_____high
Animal fat (meat, cheese, butter, eggs):_____low_____moderate_____high

Would you like a consultation with a dietician while at the Clinic? _____yes _____no

REVIEW OF SYSTEMS (Circle)

Yes No Have you gained or lost more than 5 lbs in the last year? Why? How Many? _____
_____
Weight at age 20:_____

Yes No Have you had a loss of appetite?

Yes No Have you been unusually fatigued or tired?

Yes No Do you have unexplained chills, fevers or night sweats?

Yes No Have you recently had a problem with rash or itch? Suspicious mole or growth?

Have you had:

Yes	No	Visual change in the past year?	Yes	No	Frequent nosebleeds?
Yes	No	Glaucoma or cataracts?	Yes	No	Sinus infections requiring antibiotics?
Yes	No	Double vision?	Yes	No	Sinus or nasal allergies?
Yes	No	Hearing loss?	Yes	No	Frequent sores in the mouth?
Yes	No	Ringing in the ears?	Yes	No	Current dental problems?
Yes	No	Frequent ear infections?	Yes	No	Frequent hoarseness?

Do you have pain, tightness, pressure or discomfort in the chest:

Yes	No	During exertion?	Yes	No	Radiating down an arm?
Yes	No	When walking in a wind or up a hill?	Yes	No	Occurring at rest?
Yes	No	When walking fast?	Yes	No	If you have chest pain or discomfort,
Yes	No	When walking in cold weather?			please describe _____
Yes	No	Disappearing if you rest?			_____

Would you like to have your carotid arteries checked for blockages? _____Yes _____No

REVIEW OF SYSTEMS (Circle)–(Continued)

Based on symptoms, risk factors or family history, would you like to have a cardiac stress test? _____Yes _____No

Have you had:

Yes	No	High blood pressure?	Yes	No	Irregular heart beat?
Yes	No	Abnormal cholesterol or triglycerides?	Yes	No	Ankle swelling
Yes	No	Unexpected or increased shortness of breath?	Yes	No	Calves aching while walking?
Yes	No	Heart murmur?	Yes	No	Phlebitis or inflamed veins?
			Yes	No	Painful varicose veins?

Have you had:

Yes	No	Frequent coughing?	Yes	No	Pneumonia?
Yes	No	Coughing up blood?	Yes	No	Bronchitis?
Yes	No	Asthma or wheezing?	Yes	No	Pleurisy?

Do you have: **Do you have indigestion or pain in the stomach or chest that:**

Yes	No	Difficulty swallowing?	Yes	No	occurs 1-2 hrs. after a meal?
Yes	No	Frequent vomiting or regurgitation?	Yes	No	Is brought on by eating fried or gassy foods?
Yes	No	A current or prior ulcer?	Yes	No	Awakens you at night?
Yes	No	A history of hepatitis or jaundice?	Yes	No	Is relieved by antacids?
			Yes	No	Or eating?
			Yes	No	Food intolerances?

Have you had in the past year:

Yes	No	Hemorrhoids?	Yes	No	Blood in the stool?
Yes	No	Diarrhea or constipation?	Yes	No	Black stool?
Yes	No	A change in bowel habit or pattern?	Yes	No	Ribbon like stool?
Yes	No	Pain with or after bowel movement?	Yes	No	Mucus in the stool?

Have you had:

Yes	No	Burning when urinating?	Yes	No	Trouble starting to urinate?
Yes	No	Urinary frequency during the day?	Yes	No	Blood in the urine?
Yes	No	Urinating more than once per night?	Yes	No	Excessive thirst?
Yes	No	Trouble holding the urine?	Yes	No	A history of kidney/urinary stone?
Yes	No	Hernia?	Yes	No	Treatment for venereal disease?

* * * * * * * * * * * * * * * * * * * *

TO BE ANSWERED BY MEN ONLY (circle):

Yes	No	Prostate trouble?	Yes	No	Do you have concerns regarding your sexual function?

* * * * * * * * * * * * * * * * * * * *

TO BE ANSWERED BY WOMEN ONLY (circle):

Yes No Are you still having menstrual periods? If not, when did you stop?

_____

Yes No Are your periods regular?

If still cycling, date of start of last menstrual period: _____

When was your last Pap smear? _____

Your last mammogram? _____

Yes No Breast biopsy?

Yes No Have you had an abnormal Pap smear?

Yes No Have you ever had bleeding between periods? When? _____

Yes No Do you have unusually heavy bleeding with your periods?

TO BE ANSWERED BY WOMEN ONLY (circle):

Yes No Do you have pelvic pain or an abnormal discharge?

Yes No Do you have a lump in the breast that concerns you?

Yes No Have you ever taken birth control pills? When? _____

Yes No Have you ever taken post-menopausal hormones? What and When? _____

_____

Yes No Have you ever had a discharge from the nipple of your breast? When? _____

How many children born alive?_____ How many miscarriages?_____

How many cesarean sections?_____Any complications of pregnancy? _____

Yes No Do you have any concerns regarding your sexual functioning?

TO BE ANSWERED BY MEN AND WOMEN

Do you have:

Yes	No	Known arthritis?	Yes	No	Current back pain?
Yes	No	Gout?	Yes	No	Pain radiating down the legs?
Yes	No	Bursitis or tendinitis?	Yes	No	Any history of back trouble or injuries?
Yes	No	Any joint pain, stiffness or swelling?			
Yes	No	Would you like to consider bone densitometry for osteoporosis?			

Have you had:

Yes	No	Do you frequently have severe headaches?			
Yes	No	Spells of dizziness?	Yes	No	Tremor, difficulty with balance,
Yes	No	A loss of consciousness?			walking or writing? (Circle)
Yes	No	Weakness or numbness in any part of the body?	Yes	No	Convulsions/seizures?
Yes	No	Significant mental or business stress?	Yes	No	Stroke - mini-stroke?
Yes	No	Depression?			
Yes	No	Would you like a stress management consultation?			
Yes	No	Do you have any emotional, sexual or interpersonal concerns you would like to discuss with a psychologist while here at the clinic?			

Have you had?

Yes	No	Heat or cold intolerance?	Yes	No	Bleeding tendency?
Yes	No	Anemia? When?_____	Yes	No	An abnormality of blood sugar?
Yes	No	Recent blood donation?	Yes	No	Thyroid problems?
Yes	No	A goiter?			

NOTICE: My signature below verifies that I have reviewed this form and the answers provided represent my best recollection of my health history.

Signature: _____

Date: _____

***If possible, please mail or fax a copy of this signed form to the Clinic prior to your visit and bring the original completed form with you at the time of your examination.**

ADDENDUM REGARDING AIDS: We do not automatically perform blood tests for detection of the Human Immunodeficiency Virus (HIV). This is the virus that causes AIDS. Such testing requires informed consent in West Virginia. The major risk factors for HIV infection are homosexual or heterosexual relations with persons of unknown risk, transfusions between 1977 and 1985, and IV drug abuse. If you feel you have a risk of having been exposed to the HIV virus, please bring this to your Clinic doctor's attention.