# DANIEL W. SAWYER, M.D.

INTERNAL MEDICINE & INFECTIOUS DISEASES

400 Locust Avenue, Suite 2A
Charlottesville, VA 22902

(434) 977-1933

## PATIENT'S PERSONAL HISTORY

Confidential Record: Information contained here will not be released without your authorization.

| Last Name | First | Middle | Social Security # | Date |
|---|---|---|---|---|
| Address | | City | State | Zip |
| Birth Date | Birth Place | Home Phone # | Business Phone # | Occupation |
| Business Address | | City | State | Zip |
| Person To Notify | | Relationship | Phone # | |
| Address | | City | State | Zip |
| Person who does not live with you, but could contact you in an emergency: | | | Phone # | |
| Address | | City | State | Zip |
| Religion | Martial Status | Date of Last Physical Exam | | |
| Doctor | | Family or Referring Physician | | |
| Address | | City | State | Zip |
| Insurance Company | Policy Number | Medicare # | Medicaid # | |
| Blue Cross-Blue Shield Information | | | | |

Circle the Highest Year you reached in school: 1 2 3 4 5 6 7 8 (Elementary) 1 2 3 4 (High) 1 2 3 4 (College)

**PRESENT MEDICAL PROBLEM:** Please state in your own words the medical problem or problems that bring you to see the doctor at this time. (Begin with the one you consider most serious and note how long you have had the described symptoms)

**PAST MEDICAL HISTORY:** Operations you have had (give name and year) _____

Disease which required hospitalization (give dates and hospital) _____

Serious illness (not requiring hospitalization - please give date) _____

Serious injuries or accidents (please give date) _____

**DRUG HISTORY:**

Are you presently taking any of the following medications?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ☐ Yes | ☐ No | Aspirin, bufferin, anacin | ☐ Yes | ☐ No | Sleeping pills | ☐ Yes | ☐ No | Water pills |
| ☐ Yes | ☐ No | Blood pressure pills | ☐ Yes | ☐ No | Thyroid Medicine | ☐ Yes | ☐ No | Antibiotics |
| ☐ Yes | ☐ No | Cortisone | ☐ Yes | ☐ No | Vitamins | ☐ Yes | ☐ No | Barbiturates |
| ☐ Yes | ☐ No | Cough medicine | ☐ Yes | ☐ No | Nasal spray | ☐ Yes | ☐ No | Birth control pills |
| ☐ Yes | ☐ No | Digitalis | ☐ Yes | ☐ No | Tranquilizers | ☐ Yes | ☐ No | Phenobarbital |
| ☐ Yes | ☐ No | Hormones | ☐ Yes | ☐ No | Weight reducing pills | ☐ Yes | ☐ No | Other drugs not listed |
| ☐ Yes | ☐ No | Insulin or diabetic pills | ☐ Yes | ☐ No | Blood thinning pills | | | |
| ☐ Yes | ☐ No | Iron or poor blood medications | ☐ Yes | ☐ No | Dilantin | | | |
| ☐ Yes | ☐ No | Laxatives | ☐ Yes | ☐ No | Shots | | | |

Name any allergies to drugs, foods, pets, etc. _____

_____

**PERSONAL HISTORY:**

Do you regularly smoke? ☐ Yes ☐ No ☐ Cigarettes Packs Per Day _____ ☐ Pipe ☐ Cigars How many years? _____

Do you drink over 6 cups of coffee a day? ☐ Yes ☐ No _____

Do you regularly drink alcohol? ☐ Yes ☐ No Type _____ How much per day? _____

What time do you go to bed at night? _____ What time do you get up in the morning? _____

List pets in home _____ Foreign Travel: (State Country and Year) _____

Armed Forces: (Years and Duties) _____

| FAMILY HISTORY: | If Living | | If Deceased | |
|---|---|---|---|---|
| | Age | Health | Age at Death | Cause |
| Father | | | | |
| Mother | | | | |
| Brothers & Sisters | | | | |
| | | | | |
| | | | | |
| Husband or Wife | | | | |
| | | | | |
| Sons & Daughters | | | | |
| | | | | |

Do you have any blood relative who has or had: (Check and give relationship)

| | | |
|---|---|---|
| ☐ Stroke _____ | ☐ Migraine _____ | ☐ Goiter _____ |
| ☐ Cancer _____ | ☐ Asthma _____ | ☐ Arthritis _____ |
| ☐ High Blood Pressure _____ | ☐ Hay Fever _____ | ☐ Colitis _____ |
| ☐ Tuberculosis _____ | ☐ Bleeding Tendency _____ | ☐ Nervous Breakdown _____ |
| ☐ Diabetes _____ | ☐ Heart Attack _____ | ☐ Rheumatic Heart _____ |
| ☐ Epilepsy _____ | ☐ Stomach Ulcers _____ | ☐ Insanity _____ |
| ☐ Leukemia _____ | ☐ Kidney Disease _____ | ☐ Congenital Heart _____ |
| ☐ Suicide _____ | | |

I hereby give Dr. Daniel Sawyer permission to file any medical expenses I have with him to my insurance company. _____ Signature

I authorize payment of medical benefits to go to Daniel W. Sawyer, M.D. _____ Signature

_____ Copy of Cards _____ Copy of Cards

8/02