Internal Medicine - Health History

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Patient Name____ Birthdate____/_____/____ Today's Date ____________

Name of prior physician _________________________________ Name and # or location of pharmacy_________________

What is the main concern that brings you in today?____
____

Other concerns (list in order of importance)____

Past Medical History

Have you had or been treated for any of the following medical problems in the past (If yes, mark box and list approximate date of initial diagnosis)

Condition	Date	Condition	Date
High blood pressure	_________	GERD or heartburn	_________
Diabetes: ☐ require insulin	_________	Irritable bowel syndrome	_________
Heart disease	_________	Ulcerative colitis/Crohn's disease	_________
Stroke/TIA (mini stroke)	_________	Colonic polyps or cancer	_________
Asthma	_________	Bleeding tendency	_________
High Cholesterol	_________	Venereal disease (STD)	_________
Cancer (include type)	_________	Anemia	_________
Hypothyroidism	_________	Schizophrenia	_________
Other thyroid problems	_________	Bipolar Disease	_________
Liver disease	_________	Depression	_________
Kidney disease	_________	Anxiety	_________
Seizures/Epilepsy	_________	Other psychiatric condition	_________
Migraines	_________	Gout	_________
Alcohol or drug abuse	_________	Rheumatoid arthritis	_________
Glaucoma	_________	Osteoarthritis	_________
Environmental Allergies	_________	Chronic Pain	_________
Emphysema/COPD	_________	Fibromyalgia	_________
Pneumonia	_________	DVT (clots in legs)	_________
Tuberculosis	_________	Pulmonary embolism (clot in lung)	_________
Other lung conditions	_________	Osteoporosis/Osteopenia	_________
AIDS or HIV(+)	_________	Any other diseases, please list _________	
Ulcer or gastritis	_________	None of the above	

Please list all your surgeries and year they occurred (reason for surgery if applies) ☐ None
____
____

List hospital admissions, date and reason (other than childbirth & above listed surguries) ☐ None______
____

Please list all current medication (list both daily and as needed medications) ☐ No Prescription Medications

	Name	Dose	Frequency		Name	Dose	Frequency
1				6			
2				7			
3				8			
4				9			
5				10			

Please list allergies to medications including what type of reaction you developed with each ☐ None
____

Habits

Smoking (type & amount per day, # of years) __________________ ☐ Non-smoker

If former smoker, # of years smoked__________ date quit ____________
Alcohol (type & amount per day)____________________________ ☐ Non-drinker
If former use, date quit ______________________________ ☐ Drink on rare occasion
Caffeine (number of cups per day) _____________________ ☐ None
Street Drugs (type & amount per day)_____________________ ☐ None
If former use, date quit ___________________________________

Social History

Marital status single married divorced widowed live with male partner live with female partner

Specify number of years in current relationship or since divorced or widowed_______________

Current occupation (specify part or full time) ____

Previous occupations ____

Place of birth _______________________________________

Highest level in school ________________________________

Name, relation, and age of people currently living with you______________________________
____
____

Family History

If adopted check box and disregard family history questions except for spouse & children
Has any blood relative had any of the following (specify relationship to you & age when diagnosed on space provided)

	Relation & Age when diagnosed		Relation & Age when diagnosed
Breast Cancer	________________	Depression	________________
Colon Cancer/Polyps (specify)	________________	Anxiety	________________
Prostate Cancer	________________	Bipolar Disorder	________________
Cancer (specify location)	________________	Schizophrenia	________________
Diabetes require insulin	________________	Other Mental Illness	________________
High Blood Pressure	________________	Alcoholism	________________
High Cholesterol	________________	Drug Problem	________________
Stroke	________________	Thyroid Problem	________________
Heart Disease	________________	Ulcer	________________
Asthma	________________	Others Not Listed	________________
Tuberculosis	________________	None of the above	

	Present age or age at time of death		Major medical problems/cause of death/mark if healthy	
Mother	____________	☐ living	____________________	☐ healthy
Father	____________	☐ living	____________________	☐ healthy
Siblings	____________	☐ living	____________________	☐ healthy
	____________	☐ living	____________________	☐ healthy
	____________	☐ living	____________________	☐ healthy
	____________	☐ living	____________________	☐ healthy
	____________	☐ living	____________________	☐ healthy
Spouse	____________	☐ living	____________________	☐ healthy
Children	____________	☐ living	____________________	☐ healthy
	____________	☐ living	____________________	☐ healthy
	____________	☐ living	____________________	☐ healthy
	____________	☐ living	____________________	☐ healthy

Review of Systems

Usual Weight __________#
Has your weight been stable in the past year?____________ Amt. Gained ________# Amt. Lost ______#
Do you exercise regularly? ____ Type of exercise, how often and how long each time ________________
Have you been following a special diet? ☐ yes If yes, type & number of calories if known _____________
☐ no

Have you had any of the following symptoms recently (mark if answer is yes)

Fever	Abdominal pain	Coughing a night
Fatigue	Constipation (on a regular basis)	Need to be propped up to sleep
Decreased appetite	Diarrhea (on a regular basis)	Swelling of legs
Increased appetite	Blood in stool/on toilet paper	Feeling unusually hot
Night sweats	Nausea	Feeling unusually cold
Hot flashes	Vomiting	Seizures
Skin problems	Frequent heartburn	Joint pain / muscle pain
Growing or changing moles	Hemorrhoids	Feeling depressed
Visual problems	Problems swallowing	Feeling anxious/nervous
Wear glasses or contacts	Frequent urination	Memory loss
Hearing problems	Burning during urination	Suicidal thoughts
Stuffy or runny nose	Blood in the urine	Lack of sex drive
Post nasal drip	Difficulty in starting urine flow	Problems falling asleep
Sore Throat	Vomited or coughed up blood	Problems staying asleep
Hoarseness	Chest pain	Frequent headaches
Shortness of breath	Palpitation/ fluttering of heart	Weakness of arms or legs
Cough	Ever passed out	Numbness or tingling of arms or legs
Wheezing	Shortness of breath at night	None of the above

Women Only

Name of gynecologist if you have one _______________

Do you wish to have your yearly gynecological exams done at this office? ☐ yes ☐ no

When was the first day of your last period? ___________

How many days between periods? __________________

Do you bleed or spot between periods? ______________

Are your periods heavy? __________________________

Approx. date of last PAP Smear? ___________ ☐ never

Have you ever had an abnormal PAP Smear?__________

Date __________

Date of last mammogram? _________

Date of last bone density scan? _____________

Type of birth control? _____________________________

Number of pregnancies? ___________________________

Do you do monthly self breast exams? ☐ yes ☐ no

Any problems? __________________________________

Men Only

Last rectal / prostate exam?________________

Last PSA?(blood test for prostate) _________

Impotence? ____________________________

Testicular lump? ________________________

Discharge from penis? ___________________

Sexually transmitted diseases? ______________

Any other problems? ______________________

Miscellaneous

Are you sexually active currently?_______________

If no, have you been sexually active in the past? _____________

Last time cholesterol was checked? _______________ What was it? _________________________________

Ever had a sigmoidoscopy or colonoscopy? ________ When & Why?_________________________________

Date of last tetanus shot? ________________________ Date of last pneumonia shot? ___________________

Do you get regular flu shots? _____________________ Have you had hepatitis B vaccines? ______________

Do you have a living will / power of attorney? ☐ yes ☐ no If you do, please bring a copy for your chart.

Patient's Signature ____ Date ___________

Reviewed By____ Date ___________