Abramovitz
Internal Medicine
A UNITY HEALTHCARE PARTNER

Internal Medicine – Health History

Ruth Abramovitz, M.D.

Patient Name_____ Birthdate____/_____/____ Today's Date _____

Email address (optional for pt portal)_____
Name of Local Pharmacy and Mail Order_____

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)

	Date		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 surgeries) ☐ 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

Please circle if you have had any of the following recently and explain below:

☐ Fever ☐ Chills	☐ Heart Rate is Slow	☐ Pain on Urination	☐ Skin Lesions	☐ Limb Weakness
☐ Feeling Poorly	☐ Heart Rate is Fast	☐ Urine leakage	☐ Skin Wound	☐ Difficulty Walking
☐ Feeling Tired	☐ Chest Pain	☐ Frequent Urination	☐ An Unusual Growth	☐ Depression
☐ Recent Wt Gain (____lbs)	☐ Heart thumping loudly	☐ Nightly Urination	☐ Change in Mole	☐ Anxiety
☐ Recent Wt Loss (____lbs)	☐ Leg Cramps w/ walking	☐ Abn Vaginal Bleeding	☐ Itching	☐ Sleep Disturbance
☐ Eye Pain	☐ Shortness of Breath	☐ Painful Periods	☐ Dry Skin	☐ Visual Hallucinations
☐ Red Eyes	☐ Wheezing	☐ Vaginal Discharge	☐ Breast Pain	☐ Suicidal
☐ Dry Eyes	☐ Cough	☐ Genital Lesion	☐ Breast Lump	☐ Emotional Problems
☐ Eyes Itch	☐ Short of breath at night	☐ Pelvic Pain	☐ Headache	☐ Hot Flashes
☐ Discharge from Eyes	☐ Abdominal Pain	☐ Testicular Pain	☐ Dizziness	☐ Erectile Dysfunction
☐ Eyesight problems	☐ Vomiting	☐ Joint pain	☐ Seizures	☐ Bulging eyes
☐ Earache	☐ Nausea	☐ Muscle aches	☐ Confusion	☐ Swollen Glands
☐ Loss of Hearing	☐ Constipation	☐ Joint Swelling	☐ Fainting	☐ Easy Bleeding
☐ Nosebleeds	☐ Diarrhea	☐ Joint Stiffness	☐ Feelings of Weakness	☐ Easy Bruising
☐ Nasal Discharge	☐ Heartburn	☐ Limb Pain	☐ Muscle Weakness	
☐ Sore Throat	☐ Blood in stool	☐ Limb Swelling		
☐ Hoarseness				

☐ **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 Signature Date

_____ _____

Reviewed by Date