West Lafayette
Internal Medicine
A UNITY HEALTHCARE PARTNER

Carlos Gambirazio, M.D.

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)

	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 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 ________________

Do you eat healthy in general? ☐ yes ☐ no

West Lafayette
Internal Medicine
A UNITY HEALTHCARE PARTNER

Carlos Gambirazio, M.D.

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

- ☐ Fever
- ☐ Fatigue
- ☐ Decreased appetite
- ☐ Increased appetite
- ☐ Night sweats
- ☐ Hot flashes
- ☐ Skin problems
- ☐ Growing or changing moles
- ☐ Visual problems
- ☐ Wear glasses or contacts
- ☐ Hearing problems
- ☐ Stuffy or runny nose
- ☐ Post nasal drip
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Abdominal pain
- ☐ Constipation (on a regular basis)
- ☐ Diarrhea (on a regular basis)
- ☐ Blood in stool/on toilet paper
- ☐ Nausea
- ☐ Vomiting
- ☐ Frequent heartburn
- ☐ Hemorrhoids
- ☐ Problems swallowing
- ☐ Frequent urination
- ☐ Burning during urination
- ☐ Blood in the urine
- ☐ Difficulty in starting urine flow
- ☐ Vomited or coughed up blood
- ☐ Chest pain
- ☐ Palpitation/ fluttering of heart
- ☐ Ever passed out
- ☐ Shortness of breath at night
- ☐ Coughing a night
- ☐ Need to be propped up to sleep
- ☐ Swelling of legs
- ☐ Feeling unusually hot
- ☐ Feeling unusually cold
- ☐ Seizures
- ☐ Joint pain / muscle pain
- ☐ Feeling depressed
- ☐ Feeling anxious/nervous
- ☐ Memory loss
- ☐ Suicidal thoughts
- ☐ Lack of sex drive
- ☐ Problems falling asleep
- ☐ Problems staying asleep
- ☐ Frequent headaches
- ☐ Weakness of arms or legs
- ☐ Numbness or tingling of arms or legs
- ☐ 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 ___________