Abramovitz
Internal Medicine
A UNITY HEALTHCARE PARTNER

Health History / Update Form

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

E-mail address_____ Would you like an E-mail invitation for Unity Patient Portal? Yes ☐ No ☐

What is the reason for your appointment today? (Please mark all that apply.)

☐ Physical Exam ☐ Physical Exam with Pap Smear

☐ Follow Up for ☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol / Triglycerides
☐ Asthma ☐ Joint Aches ☐ Depression / Anxiety
☐ Hypothyroidism ☐ Osteopenia / Osteoporosis ☐ GERD
☐ Hay fever / Sinus Problems ☐ Other_____

☐ New Problem (Please explain.):_____

1. Since your last physical exam have you had any new diagnosed medical problems? ☐ YES ☐ NO
   If yes, please explain:_____

2. Since your last physical exam have you had any surgeries? ☐ YES ☐ NO
   If yes, please explain:_____

3. Since your last physical exam have you had any allergic reaction to medications? ☐ YES ☐ NO
   If yes, please list the medication and the reaction:_____

4. Do you smoke? ☐ YES ☐ NO If yes, how much?_____

5. Do you drink alcohol on a regular basis? ☐ YES ☐ NO If yes, how much?_____

6. Do you have any close relatives with the following conditions? ☐ YES ☐ NO
   Check any that apply and explain below, please list any additional.
   ☐ Breast Cancer ☐ Colon Cancer ☐ Diabetes ☐ Heart Disease
   _____
   _____

7. Do you exercise on a regular basis? ☐ YES ☐ NO
   If yes, what kind of exercise?_____How often?_____times per week
   How long?_____minutes/time

8. Do you follow a specific diet? ☐ YES ☐ NO
   If yes, what kind?_____

9. 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**

If you are diabetic: ☐ Not Applicable

1. How often do you check your sugars?_____
2. What have your sugars been recently? Highest_____Lowest_____Average_____
3. When was your last eye exam?_____Do you have diabetic eye disease? ☐ YES ☐ NO
4. Do you follow a diabetic diet?_____
5. Do you look at your feet everyday? ☐ YES ☐ NO Any problems?_____
6. Have you seen the diabetes educator? ☐ YES ☐ NO When was the last time?_____

If you have hypertension: ☐ Not Applicable

1. Do you check your blood pressure at home or elsewhere? ☐ YES ☐ NO
   If yes, how often?_____
   Please list your recent readings:_____

If you have high cholesterol / triglycerides: ☐ Not Applicable

1. Have you been following a low cholesterol diet? ☐ YES ☐ NO
2. If you are on cholesterol medication, have you had any unusual body aches or weaknesses? ☐ YES ☐ NO

10. Have you received any immunizations since your last visit? ☐ YES ☐ NO
    ☐ Tetanus ☐ Pneumonia ☐ Shingles ☐ Gardasil (HPV) ☐ Flu Shot ☐ Other:_____

If this is your yearly exam: ☐ Not Applicable

When doing a yearly exam we will also do a follow up appointment for any medical conditions you may have and medications you are prescribed. This will be reflected in your charges. If you would like to only do your physical today please schedule an appointment for your follow up before leaving and notify the nurse that you will do this at a later date.

Females

☐ Hysterectomy? If yes did you have both ovaries removed ☐ Only Left ovary ☐ Only Right ovary ☐
☐ Postmenopausal (Any postmenopausal bleeding? ☐ YES ☐ NO)

1. First day of your last menstrual period?_____
2. What type of birth control do you use?_____
3. Are your periods regular?_____Are they heavy?_____
4. Are you sexually active? ☐ YES ☐ NO Any problems with intercourse?_____

Males

1. Any problems with sexual function? ☐ YES ☐ NO
2. Any testicular lumps? ☐ YES ☐ NO
3. Any penile discharge? ☐ YES ☐ NO

Please list all of your current prescription medications including strength and dosage. ☐ Not Applicable

Medication	Dosage	Frequency	Prescribed by: (if another M.D.)

Use back of page for additional medications.

_____ _____ _____ _____
Patient Signature Date Reviewed by Date