INTERNAL MEDICINE & FAMILY PRACTICE, SC

PATIENT SELF HISTORY

NAME: _____ DATE: _____

BIRTHDATE: _____ REASON FOR VISIT _____

SURGICAL PROCEDURES

YEAR		PROCEDURE	FACILITY/PHYSICIAN

MEDICAL HISTORY

(CIRCLE ALL PAST OR PRESENT PROBLEMS OR SYMPTOMS)

ANEMIA
ARTHRITIS
ASTHMA
CANCER
DIABETES 1 OR 2
HIV
GOUT
LIVER DISEASE
LUNG DISEASE
HEARING LOSS
VISUAL LOSS
HEART ATTACK
HEART DISEASE
CHEST PAIN
HIGH BLOOD PRESSURE
KIDNEY DISEASE
PROSTATE DISEASE
URINARY INCONTINENCE
DIFFICULTY URINATING
THYROID DISEASE
GLAUCOMA
SHORTNESS OF BREATH
ULCERS
GASTROINTESTINAL BLEED
ANY OTHER BLEEDING
EASY BRUISABILITY
PSYCHIATRIC PROBLEMS
SEIZURE
STROKE
TUBERCULOSIS
SEXUALLY TRANSMITTED DISEASE
OTHER: _____

DRUG/ALCOHOL ABUSE
CURRENTLY: IN RECOVERY OR ACTIVE

MEN only

ABNORMAL PENILE DISCHARGE
BREAST LUMP
ERECTION DIFFICULTIES
LUMP IN TESTICALS
SORE ON PENIS

WOMEN only

ABNORMAL VAGINAL DISCHARGE
BREAST LUMP/PAIN
ABNORMAL PAP SMEAR
EXTREME MENSTRUAL PAIN
HOT FLASHES
NIPPLE DISCHARGE
FIBROIDS

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NAME (print): _____ DOB: _____

ALLERGIES (FOOD & DRUG) OR N/A	REACTION/SEVERITY OR N/A

SOCIAL HISOTRY

TOBACCO USE? YES NO	YEAR STARTED/ENDED?	TYPE?
ALCOHOL USE? YES NO	YEAR STARTED/ENDED?	HOW MUCH?
DO YOU USE YES NO RECREATIONAL DRUGS?	HOW OFTEN?	WHAT KIND?

FAMILY HISTORY

Father, Mother, Siblings, Grandparents, Aunts & Uncles – If adopted mark as unknown

DISEASE	RELATIONSHIP TO YOU	RELATIONSHIP TO YOU	RELATIONSHIP TO YOU	RELATIONSHIP TO YOU
ARTHRITIS, GOUT				
ASTHMA HAY FEVER				
CANCER				
DEPRESSIVE DISORDER				
DIABETES				
HEART DISEASE STROKE				
KIDNEY DISEASE				
TUBERCULOSIS				

GENERAL QUESTIONS:

ANY EXPOSURE TO HAZARDOUS SUBSTANCES, DUST, FUMES, SMOKE, AND/OR NOISE? _____

DO YOU WATCH YOUR DIET OR FOLLOW STRICT DIETARY GUIDELINES? _____

DO YOU EXERCISE REGULARLY? Y / N TIMES PER WEEK FOR _____ HOURS/MINUTES.

DO YOU TAKE ANY NON-PRESCRIPTION MEDICATIONS, HEALTH FOODS, AND/OR VITAMINS? Y / N

PLEASE LIST: _____

_____

SIGNATURE: _____ **DOB:** _____