INTERNAL MEDICINE HEALTH HISTORY

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any of these questions, do not answer it. If you cannot remember specific dates, please provide a year. Add any notes you think may be important. ALL QUESTIONS CONTAINED IN THIS FORM ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:_____

Other concerns:_____

PREFERRED PHARMACY:_____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

	ALLERGY	**REACTION**
1.		
2.		
3.		
4.		
5.		

MEDICATIONS

Please list all the medications you are taking. Please include all prescribed drugs, over the counter drugs and all supplements.

	Drug Name	Strength	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

IMMUNIZATION

Immunizations and most recent date:

- ❑ Chickenpox Date:_____
- ❑ Flu Shot Date:_____
- ❑ Gardasil/HPV Date:_____
- ❑ Hepatitis A Date:_____
- ❑ Hepatitis B Date:_____
- ❑ Meningococcus Date:_____
- ❑ MMR Date:_____
- ❑ Tetanus Date:_____
- ❑ Shingles Date:_____
- ❑ Pneumonia Date:_____

WOMAN ONLY: OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date:_____ Abnormal: Yes___ or No____

Last Mammogram Date:_____ Abnormal: Yes___ or No____

Age of first menstrual cycle:_____

Date of last menstrual cycle:_____

Age started menopause:_____

Number of Pregnancies:_____

Number of Births:_____

Number of Miscarriages:_____

Number of Abortions:_____

Cesarean Section: Yes_____ or No_____ How many:_____

Bleeding between periods: Yes_____ or No_____

Heavy periods: Yes_____ or No_____

Extreme menstrual pain: Yes_____ or No_____ How long does the pain last:_____

Vaginal itching, burning, or discharge: Yes_____ or No_____

Wake up in the night to go to the bathroom: Yes_____ or No_____

Hot Flashes: Yes_____ or No_____

Breast lump or nipple discharge: Yes_____ or No_____

Painful intercourse: Yes_____ or No_____

Sexually Active: Yes_____ or No_____

Do you use condoms: Yes_____ or No_____

Other birth control method used:_____

Would you like to be screened for STD's: Yes_____ or No_____

Men Only:

Last Prostate Examination:_____ Out Come of Examination:_____

Erectile Dysfunction: Yes/No

Sexual Active: Yes/No

Vasectomy: Yes/No

If yes when:_____

Do you have or have you ever been diagnosed with any sexually transmitted diseases: Yes/No

If yes what were they and when:_____

Decrease Urinary Flow: Yes/No

PAST MEDICAL HISTORY

Please check all that apply:

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Blood Clots
- ❑ Cancer
- ❑ Coronary Artery Disease
- ❑ Claustrophobic
- ❑ Diabetes – Insulin
- ❑ Diabetes – Non-insulin
- ❑ Dialysis
- ❑ Diverticulitis
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Pacemaker
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Hiatal Hernia or Reflux Disease
- ❑ HIV or AIDS
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Overactive/ Underactive Thyroid
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Leg/Foot Ulcers
- ❑ Liver Disease
- ❑ Osteoporosis
- ❑ Polio
- ❑ Pulmonary Embolism
- ❑ Reflux or Ulcers
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

3. _____ _____ _____ _____
4. _____ _____ _____ _____
5. _____ _____ _____ _____

FAMILY HEALTH HISTORY

Relation	Alive	Age	Health Problems
(Maternal)			
Grandmother	**Yes/No**	**_____**	**Alcoholism Arthritis Depression Cancer Diabetes Genetic Disease Heart Disease Hypertension Osteoporosis Stroke**
Grandfather	**Yes/No**	**_____**	**Alcoholism Arthritis Depression Cancer Diabetes Genetic Disease Heart Disease Hypertension Osteoporosis Stroke**
(Paternal)			
Grandmother	**Yes/No**	**_____**	**Alcoholism Arthritis Depression Cancer Diabetes Genetic Disease Heart Disease Hypertension Osteoporosis Stroke**
Grandfather	**Yes/No**	**_____**	**Alcoholism Arthritis Depression Cancer Diabetes Genetic Disease Heart Disease Hypertension Osteoporosis Stroke**
Father	**Yes/No**	**_____**	**Alcoholism Arthritis Depression Cancer Diabetes Genetic Disease Heart Disease Hypertension Osteoporosis Stroke**
Mother	**Yes/No**	**_____**	**Alcoholism Arthritis Depression Cancer Diabetes Genetic Disease Heart Disease Hypertension Osteoporosis Stroke**
Brother/Sister	**Yes/No**	**_____**	**Alcoholism Arthritis Depression Cancer Diabetes Genetic Disease Heart Disease Hypertension Osteoporosis Stroke**

Brother/Sister Yes/No _____ Alcoholism Arthritis Depression Cancer Diabetes

Genetic Disease Heart Disease Hypertension

Osteoporosis Stroke

Other:_____

Social History

Education:

- ❑ Less than 8th grade
- ❑ High School
- ❑ 2 years of college
- ❑ 4 years of college
- ❑ Post Graduate

Caffeine:

None
Occasional
Moderate
Heavy
Number per day_____

Alcohol:

Do you drink alcohol: Yes/No
If so often:_____
How many drinks a week:____

Do you currently use recreational or street drugs: Yes/No

If yes please list:_____

Do you use Tobacco: Yes/ No If not currently, have you ever used Tobacco: Yes/No

- ❑ Cigarettes- _____ pks/day
- ❑ Chew- _____ day
- ❑ Cigars- _____
- ❑ Number of years_____
- ❑ What year did you quit:_____

Exercise Level:

- ❑ None
- ❑ Occasional exercise
- ❑ Moderate exercise
- ❑ High level exercise

Please add any other information about your health that you would like your provider to know:

_____ _____

Patient, Parent, Guardian, or Caregiver Signature **Date**