Patient Name__________________________ **DOB**___________________________

Internal Medicine Health History Questionnaire

Main reason for today's visit and/or concerns:

____

____

Patient Pharmacy: ____

Patient Lab: ____

Patient Imaging: ____

Allergies (to medications, food, pollen, etc. and how it affects you):

Allergen	Reaction

Medications (list all prescription and over the counter drugs):

Drug Name	Strength	Frequency Taken

Immunizations:

Chickenpox	Date: ___________	Meningococcus	Date: ___________
Influenza	Date: ___________	MMR	Date: ___________
Gardasil/HPV	Date: ___________	Pneumonia	Date: ___________
Hepatitis A	Date: ___________	TDAP	Date: ___________
Hepatitis B	Date: ___________	Tetanus	Date: ___________
Meningococcus	Date: ___________		

Patient Name_________________________ **DOB**__________________________
Family History (circle):

M. Grandmother	**M. Grandfather**	**P. Grandmother**	**P. Grandfather**
Alcoholism Arthritis Depression Cancer Diabetes Heart Disease Hypertension Osteoporosis Stroke Other	Alcoholism Arthritis Depression Cancer Diabetes Heart Disease Hypertension Osteoporosis Stroke Other	Alcoholism Arthritis Depression Cancer Diabetes Heart Disease Hypertension Osteoporosis Stroke Other	Alcoholism Arthritis Depression Cancer Diabetes Heart Disease Hypertension Osteoporosis Stroke Other
Father	**Mother**	**Brother(s)**	**Sister(s)**
Alcoholism Arthritis Depression Cancer Diabetes Heart Disease Hypertension Osteoporosis Stroke Other	Alcoholism Arthritis Depression Cancer Diabetes Heart Disease Hypertension Osteoporosis Stroke Other	Alcoholism Arthritis Depression Cancer Diabetes Heart Disease Hypertension Osteoporosis Stroke Other	Alcoholism Arthritis Depression Cancer Diabetes Heart Disease Hypertension Osteoporosis Stroke Other

Social History:

Do you smoke? Yes/No

If so, how much? ________________

For how long? ________________

Education level: ____

Occupation: ____

Are you employed? Yes/No

Do you live: Alone/With others

Number of children: ________________

Exercise level: None/Occasional/Moderate/Heavy

Stress level: Low/Medium/High

Any diet restrictions? ____

Caffeine use: None/Occasional/Moderate/Heavy

Alcohol use: None/Occasional/Moderate/Heavy

Chewing tobacco: None/1 time per day/2-4 times per day/5+ times per day

Illicit drug use: ____

Patient Name__________________________ **DOB**___________________________

GYN History (women only):

Last PAP smear	Date: ___________	Result (circle):	Normal/Abnormal
Last mammogram	Date: ___________	Result (circle):	Normal/Abnormal

Last menstrual cycle Date: ___________ Age of menopause: __________

OB History (women only):

Births: ___________ Miscarriages Induced: ___________
Cesarean sections: ___________ Miscarriages Spontaneous: ___________

Sexual History:
Are you sexually active (circle)? Yes/No
My current sexual partner is (circle): Male/Female
Do you use condoms (circle)? Yes/No
Birth control used? ____

Past Surgical History:

Surgery	**Reason**	**Date/Year**	**Location**

Patient Name__________________________ DOB__________________________

Past Medical History (check):

ADD/ADHD	AIDS/HIV	Abuse/Domestic Violence
Allergies/Hay fever	Anemia	Anesthesia Complications
Anxiety Disorder	Arthritis	Asthma
Autism Spectrum Disorder	Bedwetting	Birth Defect/Inherited Disease
Bladder/Kidney Problem	Blood Diseases	Blood Transfusion
Breast Cancer	Breast Problems	COPD
Cancer	Chickenpox	Chronic Ear Infections
Congestive Health Failure	Constipation	Coronary Artery Disease
Depression	Developmental Disorder	Diabetes
Difficulty Swallowing	Diverticulitis	Ear or Hearing Problems
Eating Disorder	Eczema	Endometriosis
Fibromyalgia	GI Problems	Gout
Headaches	Heart Disease	Heart Problems
Hepatitis	High Cholesterol	High Hospitalizations
Hypertension	Hyperthyroidism	Hypothyroidism
Infertility Disorder	Kidney Disease	Kidney Stone
Liver Disease	Lung Disease	MRSA Exposure
Meniere's Disease	Mental Disorder	Mental Illness
Muscle/Joint/Bone Problems	Obesity	Osteoporosis
Other	Ovarian Cancer	Polyps
Pre-Eclampsia	Pulmonary Embolism	Reflux/GERD
Seizure Disorder/Epilepsy	Skin Problems	Stroke
Thrombophlebitis	Thyroid Problems	Tuberculosis
Varicosities	Vision/Eye Problems	

Any other information you would like to tell us about your health?

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