Clermont Internal & Cosmetic Medicine
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MEDICAL HISTORY FORM

Name:_____Gender: M ❑ F ❑ DOB:_____Date:_____

Your answers on this form will help us better understand your medical concerns and conditions.
If you are uncomfortable with any questions, please simply do not answer it.
If you cannot remember specific details, please provide your best guess. Thank you!

What is the reason for your visit with CICM? _____

How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

REVIEW OF SYMPTOMS: (Please check any CURRENT symptoms you are experiencing)

Constitutional	**Respiratory**	**Skin**
❑ Unexplained weight loss/gain	❑ Cough/wheeze	❑ New or change in mole ❑ Rash
❑ Unexplained fatigue/weakness		
Eyes	**Gastrointestinal**	**Neurological**
❑ Change in vision	❑ Heartburn/reflux	❑ Memory loss
	❑Nausea/vomiting/diarrhea	❑ Fainting
Ears/Nose/Throat/Mouth	**Genitourinary**	**Psychiatric**
❑ Sore Throat	❑ Burning with Urination	❑ Anxiety/stress
❑ Trouble swallowing	❑ Leaking urine	❑ Sleep Difficulty
❑ Sinus Problems	❑ Nighttime urination	
	❑ Discharge: penis or vagina	
Cardiovascular	❑ Concern with sexual functions	**Blood/Lymphatics**
❑ Chest pain/discomfort		❑Lymph node tenderness or swelling?
❑ Palpitations ❑ Shortness of breath with exertion		❑ Easy bruising
Breast	**Musculoskeletal**	**Endocrine**
❑ Breast lump	❑ Muscle/joint pain	❑ Cold/heat intolerance
❑ Nipple discharge	❑ Back pain	❑ Increased thirst/appetite

Do you have any ALLERGIES or REACTIONS to any MEDICATIONS? Yes ❑ No ❑

If yes, please list the **MEDICATIONS to which you are allergic and specify the REACTIONS**
1._____
2._____
3._____
4._____
5._____

SURGICAL HISTORY: Please list **ANY and ALL prior surgeries (including as a child**) and provide dates. If unsure of date, please include your age or year:
_____
_____
_____
_____
_____

Dates of your most recent **IMMUNIZATIONS**:
Hepatitis A:_____ Hepatitis B: 1)_____2)_____3_____ Influenza (flu shot):_____
MMR:_____
Tetanus (Td):_____Pneumovax (pneumonia):_____Meningococcal _____
Varicella (chicken pox) shot or illness:_____HPV:_____
Zostavax (Shingles):_____

HEALTH MAINTENANCE SCREENING TESTS:
Lipid (cholesterol) & Glucose (Sugar) : Date:_____Abnormal? Yes ❑ No ❑
Sigmoidoscopy ❑ or Colonoscopy ❑ Date:_____Abnormal? Yes ❑ No ❑

Do you see any other doctors? If yes, please list their names and specialty.
1. _____
2. _____
3. _____
4. _____
5. _____

Women: Mammogram Date:_____Abnormal? Yes ❑ No ❑
Pap Smear Date: _____ Abnormal? Yes ❑ No ❑
Dexa Scan Date: : _____Abnormal? Yes ❑ No ❑

Reproductive Health History:

Number of: Pregnancies_____ Live births_____ Miscarriages_____ Abortions_____
Age at onset of menstrual cycles: _____ Date of last menses:_____
Age at end of menstruation/menopause: _____
Name and phone number of your OB/Gyn:_____

Men's Health History:
Have you had a blood test for PSA (prostate) Yes ❑ No ❑ If yes, what date:_____
Was it normal? Yes ❑ No ❑

PERSONAL MEDICAL HISTORY: Please indicate all medical problems that you HAVE Or HAD

_____
_____
_____
_____
_____
_____
_____

MEDICATIONS: Please list ALL medications that you are taking INCLUDING over the counter medications.

_____
_____
_____
_____
_____

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Relative	Date of Birth	Alive/ Deceased (list age when died)	List any Health Problems or Cause of Death
Father			
Mother			
Sibling			
Sibling			
Child			
Child			
Child			

Patient Name: _____ Date: _____