Social ,Educational and Work history

Marital Status:		Age of children if any:
Work Status(circle one) Employed Unemployed / Retired / Disabled	Current or prior Occupation	Hours worked per week
What type of exercise do you perform,duration & frequency?		
Type of residence do you live(i.e. House,assisted living,nursing home)?		
Hobbies?		
Do you drink alcohol?	Type of Alcohol?	
Are you current smoker?	How many packs per day	
Are you former smoker?	What year did you quit?	# years you smoked?
On Average,how much did you smoke per day?		
Are you sexually active? YES NO	Do you have sex with Men Women Both	How many partners have you had during past 12 months?
Are you concerned that you may have been exposed to HIV? YES NO		

Family Health History

please list below the health history of your blood (genetic) first degree relatives

Relative	Living or Deceased	Current age Age at Death	Cause of Death	Health Problems
Father				
Mother				
Brother(s)				
Sister(s)				

REVIEW of SYSTEMS

please review the following symptoms and circle those that are a problem for you

VISION PROBLEM	WHEEZING	LUMP ON BREAST	Frequent urination	Excessive hunger
HEARING PROBLEM	ASTHMA/COPD	BREAST DISCHARGE	Incontinence	Excessive thirst
SINUS TROUBLE	EMPHYSEMA	TROUBLE SWALLOWING	Blood in Urine	Weakness
FEVER	BRONCHITIS	NAUSEA	History of STD's	Fatigue
NOSE BLEEDS	TB EXPOSURE	VOMITING	Anemia	Fever/Sweating
SORE THROAT	CHEST PAIN	ABDOMINAL PAIN	Easy Brusing	Fainting
HOARSENESS	CHEST DISCOMFORT	HEPATITIS/JAUNDICE	Pain in legs	Seizures / Tremor
LUMP ON NECK	SHORT OF BREATH	GALLSTONES	Joint Pain /stiffness	Headaches
TOOTH PROBLEM	HIGH BLOOD PRESSURE	DIARRHEA	Blood Clot	Numbness/tingling
COUGH	DIABETES	CONSTIPATION	Weight gain / loss	Anxiety / Depression
COUGHING BLOOD	HIGH CHOLESTEROL	Blood in stool	Heat Cold Intolerance	Difficulty Sleeping

Disease Prevention and Health Maintenance

Flu Vaccine		Colonoscopy		Eye Exam	
Pneumonia Vaccine		Pap Smear		Endoscopy	
Mammogram		Bone density		Heart Stress Test	

Hope Internal Medicine & Sleep

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New Patient Medical History

Name:______________________ Date of Bith____/____/____ Age:_____ Sex:
How did you hear about our Practice?

Briefly state in the box below the reason for your visit

Medical History

Condition/Disease	Year Began	Condition/Disease	Year Began

Past Surgical Procedures/Hospitalization/Serious Injuries or Fractures

Operation/Hospitalization/Injury	Month /Year	Operation/Hospitalization/Injury	Month /Year

Specialist you currently see

Medication or Food Allergies or Intolerance

list below medication or food causing an allergic reaction(i.e ,rash,swelling)or intolerance(i.e. , nausea)

Medication /Food	Reaction	Medication /Food	Reaction

Medications,Vitamins and Herbal Supplements

Medication	Strength	Frequency	Medication	Strength	Frequency
Example: Tylenol	**500 mg**	**1- twice day**			