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Internal Medicine

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A MEDICAL CORPORATION

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Name _____ Gender _____ Age _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Allergies ☐ Anemia ☐ Anxiety Disorder ☐ Arthritis ☐ Asthma ☐ AIDS / HIV
☐ Back Problems ☐ Bleeding Disorder ☐ Blood Disease ☐ Blood Transfusion ☐ Cancer ☐ Diabetes ☐ Depression
☐ Ear Problems ☐ Eating Disorder ☐ Epilepsy ☐ Glaucoma ☐ Gout ☐ Heart Disease ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ High Blood Pressure ☐ High Cholesterol ☐ Joint Disorder ☐ Kidney Disorder ☐ Liver Disorder ☐ Lung Disease
☐ Measles ☐ Migraines ☐ Osteoporosis ☐ Pneumonia ☐ Polio ☐ Rheumatic Fever ☐ Stroke
☐ Skin Disorder ☐ Stomach Ulcer ☐ Substance Abuse ☐ Thyroid Disorder ☐ Tuberculosis ☐ Venereal Disease

Hospitalizations & Surgeries

Reason	Date

Prevntative Care

Last Colonoscopy _____ Last Mammogram _____ Last Pap Smear _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Allergies ☐ Alzheimer's ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ AIDS/HIV ☐ Bleeding Disorder ☐ Blood Disorder
☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Disorder ☐ Glaucoma ☐ Heart Disease ☐ Hepatitis ☐ High Cholesterol ☐ High Blood Pressure
☐ Joint Disorder ☐ Kidney Disease ☐ Liver Disorder ☐ Lung Disease ☐ Migraines ☐ Psychiatric Disorders ☐ Osteoporosis ☐ Stroke ☐ Substance Abuse ☐ Thyroid Disorder

Details: _____

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How often do you exercise?

times/week _____