A-Z Internal Medicine
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MEDICAL HISTORY

Date: _____

Patient Name: _____ Date of Birth: _____
(Last) (First) (MI)

MEDICAL HISTORY List all your known medical conditions:

SURGERY/INJURY List previous surgeries or injuries and approximate year:

Surgery/Injury	Year	Surgery/Injury	Year

HOSPITALIZATIONS List reasons for any previous hospital admissions and approximate year(s):

Reason	Year	Reason	Year

FAMILY HISTORY List family member and approximate age of onset:

Disease	Family Member	Age of Onset
Strokes		
High Blood Pressure		
Heart Disease		
Diabetes		
Depression / Mental Illness / Suicide		
Cancer / What Type?		

CURRENT MEDICATIONS ☐ No ☐ Yes If yes, please list medications & dosage

Medication	Dosage	Medication	Dosage

DRUG ALLERGIES ☐ No ☐ Yes If yes, please list medications & reaction

Medication	Reaction	Medication	Reaction

IMMUNIZATIONS

Type	Date
Tetanus	
Flu	
Pneumonia	

SOCIAL HISTORY

Marital Status _____ Occupation _____

Number of Children _____

Tobacco use: Current or Past _____ Quantity/day _____

Alcohol: Current or Past _____ Quantity/day _____

Recreational drugs: Current or Past _____ Quantity/day _____

HIV/AIDS Risk: _____ ☐ Check if not sure

HEALTH MAINTENANCE

Date of last: Eye Exam?_____

Colonoscopy? _____

(Female Patients)

Pap? _____

Mammogram? _____