INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes that are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIE ARE OPTIONAL AND WILL BE KEPT CONFIDENTIAL.

Main reason for today's visit: _____
_____
_____

List anything that you are allergic to {medications, food, bee stings, ect.} and how each affects you.

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

FAVORITE PHARMACIES

LOCAL PHARMACY _____
MAIL ORDER _____

MEDICATIONS

Please list all the medications you are talking. Including prescription drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

IMMUNIZATION HISTORY

Immunizations are most recent date:

Chickenpox	Date: _____	Meningococcus	Date: _____
Flu Shot	Date: _____	MMR(Measles, Mups, Rubella)	Date: _____
Gardisil/HPV	Date: _____	Pnuemonia	Date: _____
Hepatitis A	Date: _____	Tdap (Tetanus and pertussis)	Date: _____
Hepatitis B	Date: _____	Tetanus	Date: _____
		Zostavax (shingles)	Date: _____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Las Pap Smear Date:_____ Abnormal:_____ Number of pregnancies: _____ births: _____
Last Mammogram Date:_____ Abnormal:_____ Miscarriages: _____ abortions: _____
Age of first menstrual period:_____ Cesarean sections: _____
Date of last menstrual period or age of menopause: _____ Hysterectomy: [ ] total [ ]partial

_____ _____ _____
PRINT NAME PATIENT SIGNATURE DATE

PAST MEDICAL HISTORY

Please check all that apply:

[ ] Anxiety Disorder
[ ] Arthritis
[ ] Asthma
[ ] Allergies (Seasonal)
[ ] Anxiety Disorder
[ ] Bleeding Disorder
[ ] Blood Clots (or DVT)
[ ] Cancer
[ ] Coronary Artery Disease
[ ] Diabetes –Insulin
[ ] Diabetes – Non Insulin
[ ] Dialysis
[ ] Diverticulitis
[ ] Fibromyalgia
[ ] Gout
[ ] Has Pacemaker
[ ] Heart Attack
[ ] Heart Murmur
[ ] Hiatal Hernia or Reflux Disease
[ ] HIV or AIDS
[ ] High Cholesterol
[ ] High Blood Pressure
[ ] Insomnia
[ ] Overactive Thyroid
[ ] Kidney Disease
[ ] Kidney Stones
[ ] Leg/Foot Ulcers
[ ] Liver Diseases
[ ] Osteoporosis
[ ] Polio
[ ] Pulmonary Embolism
[ ] Reflux or Ulcers
[ ] Stroke
[ ] Sleep apnea
[ ] Tuberculosis
[ ] Other

FAMILY HEALTH HISTORY

Grandmother (maternal) Y/N _____ [ ] ALCOHOLISM [ ] ARTHRITIS [ ] DEPRESSION [ ] CANCER [ ]DIABETES [ ] HEART DISESE [ ] HYPERTENTION [ ] OSTEOPOROSIS [ ] STROKE

Grandfather (maternal) Y/N _____ [ ] ALCOHOLISM [ ] ARTHRITIS [ ] DEPRESSION [ ] CANCER [ ]DIABETES [ ] HEART DISESE [ ] HYPERTENTION [ ] OSTEOPOROSIS [ ] STROKE

Grandmother (parental) Y/N _____ [ ] ALCOHOLISM [ ] ARTHRITIS [ ] DEPRESSION [ ] CANCER [ ]DIABETES [ ] HEART DISESE [ ] HYPERTENTION [ ] OSTEOPOROSIS [ ] STROKE

Grandfather (parental) Y/N _____ [ ] ALCOHOLISM [ ] ARTHRITIS [ ] DEPRESSION [ ] CANCER [ ]DIABETES [ ] HEART DISESE [ ] HYPERTENTION [ ] OSTEOPOROSIS [ ] STROKE

Father Y/N _____ [ ] ALCOHOLISM [ ] ARTHRITIS [ ] DEPRESSION [ ] CANCER [ ]DIABETES [ ] HEART DISESE [ ] HYPERTENTION [ ] OSTEOPOROSIS [ ] STROKE

Mother Y/N _____ [ ] ALCOHOLISM [ ] ARTHRITIS [ ] DEPRESSION [ ] CANCER [ ]DIABETES [ ] HEART DISESE [ ] HYPERTENTION [ ] OSTEOPOROSIS [ ] STROKE

Brother/Sister Y/N _____ [ ] ALCOHOLISM [ ] ARTHRITIS [ ] DEPRESSION [ ] CANCER [ ]DIABETES [ ] HEART DISESE [ ] HYPERTENTION [ ] OSTEOPOROSIS [ ] STROKE

Brother/Sister Y/N _____ [ ] ALCOHOLISM [ ] ARTHRITIS [ ] DEPRESSION [ ] CANCER [ ]DIABETES [ ] HEART DISESE [ ] HYPERTENTION [ ] OSTEOPOROSIS [ ] STROKE

Other:_____ Y/N _____ [ ] ALCOHOLISM [ ] ARTHRITIS [ ] DEPRESSION [ ] CANCER [ ]DIABETES [ ] HEART DISESE [ ] HYPERTENTION [ ] OSTEOPOROSIS [ ] STROKE

Please add any other information about your health that you would like your provider to know here:

_____

_____

_____

_____

_____

_____

SEXUAL HEALTH

[ ] Sexually Active
Current sexual partner is female/male
Do you use condoms? Yes/No
Other birth control methods used: _____
[ ] Interested in being screened for STDs

[ ] Not Sexually Active

_____ _____ _____

PRINT NAME PATIENT SIGNATURE DATE

SOCIAL HISTORY

Occupation: _____
_____

Education: [ ] Less than 8th grade
[ ]High School [ ]2 yr college [ ]4 yr college [ ] Post Graduate

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated
[ ] Widowed [ ] Domestic Partner

Exercise Level :
[ ] None (No exercise)
[ ] Occasional
[ ] Moderate
[ ] High Level

Caffeine:
[ ] None [ ] Occasionally
[ ] Moderate [ ] Heavy
# of cups per day _____

Alcohol: Do you drink alcohol?
[ ] Yes [ ] No
If so, how often?
[ ] Occasionally [ ] Moderate
[ ] Heavy
How many drinks a week? _____

Drugs: Do you currently use recreations or street drugs?
[ ] Y [ ]N
If yes, please list: _____
_____

Tobacco: Do you use tobacco?
[ ] Yes [ ] No

If yes, smoked since age : _____
# of packs per day: _____
If not currently, did you use tobacco?
[ ] cigarettes-_____/per day
[ ] chew-_____/per day
[ ] cigars-_____/per day
[ ] # of years-_____

REVIEW OF SYSTEMS

Allergic/Immunologic
[ ] Frequent Sneezing
[ ] Hives
[ ] Itching
[ ] Runny Nose
[ ] Sinus Pressure
[ ] Arm Pain or Exertion

Cardiovascular
[ ] Chest Pain on Exertion
[ ] Chest Heaviness/ Pressure on Exertion
[ ] Irregular Heart Palpitations
[ ] Known Heart Murmur
[ ] Light-headed on Standing
[ ] Shortness of Breath when Lying Down
[ ] Shortness of Breath when Walking
[ ] Swelling (Edema)

Constitutional
[ ] Exercise Intolerance
[ ] Fatigue
[ ] Fever
[ ] Weight Gain (_____ lbs)
[ ] Weight Loss (_____ lbs)

Eyes
[ ] Dry Eyes
[ ] Irritation
[ ] Vision Changes

Ears/Nose/Mouth/Throat
[ ] Bleeding Gums
[ ] Difficulty Hearing
[ ] Dry Mouth
[ ] Ear Pain
[ ] Frequent Infections
[ ]Frequent Nose Bleeds
[ ] Hoarseness
[ ] Mouth Breathing
[ ] Mouth Ulcers
[ ] Nose/Sinus Problems
[ ] Ringing in Ear

Endocrine
[ ] Fatigue
[ ] Increased Thirst/ Hunger/Urination

Gastrointestinal
[ ] Abdominal Pain
[ ] Black or Tarry Stool
[ ] Blood in Stool
[ ] Changes in Appetite
[ ] Frequent Indigestion
[ ] Hemorrhoids
[ ] Trouble Swallowing
[ ] Vomiting
[ ] Vomiting Blood

Genitourinary
[ ] Blood in Urine
[ ] Difficulty Urinating
[ ] Incomplete Emptying
[ ] Incr. Urinary Frequency
[ ]Urinary Loss of Control

Gynecological
[ ] Bleeding between periods
[ ] Heavy periods
[ ] Extreme menstruation pain
[ ] Vaginal itching, burning, or discharge
[ ] Wake in the night to go to the bathroom
[ ] Hot flashes
[ ] Breast lump or nipple discharge
[ ] Painful intercourse

Hematologic/Lymphatic
[ ] Easy Bruising/Bleeding
[ ] Swollen Glands

Integumentary (Skin)
[ ] Changes in Moles
[ ] Dry Skin
[ ] Eczema
[ ] Growth/Lesions
[ ] Itching
[ ] Jaundice (Yellow skin/eyes)
[ ]Rash

Musculoskeletal
[ ] Back Pain
[ ] Joint Pain
[ ] Muscles Aches
[ ] Muscle Weakness

Neurological
[ ] Dizziness
[ ] Fainting
[ ] Headaches
[ ]Memory Loss
[ ] Migraines
[ ] Numbness
[ ] Restless legs
[ ] Seizures
[ ] Weakness

Psychiatric
[ ] Alcohol Overuse
[ ] Anxiety/Stress
[ ] Depression
[ ] Do Not Feel Safe in Relationship
[ ] Mania
[ ]Sleep Problems

Respiratory
[ ] Cough
[ ] Coughing Up Blood
[ ] Shortness of Breath
[ ] Snoring
[ ] Wheezing

Date of last colonoscopy: _____

Date of last eye exam: _____

Name of eye doctor: _____

_____ _____ _____
PRINT NAME PATIENT SIGNATURE DATE