Internal Medicine Health History Form

Please fill out health form to the best of your ability and bring to your first appointment

Name: ____

Age: ___________ Date of Birth: ______________________

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REASON FOR TODAY'S APPOINTMENT:

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HEALTH CARE PROVIDERS IN PAST 5 YEARS:

Name	Physician Specialty	Are you still seeing?
______________________________________	________________________________	☐ Yes ☐No
______________________________________	________________________________	☐ Yes ☐No
______________________________________	________________________________	☐ Yes ☐No

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PERSONAL MEDICAL HISTORY: Have you ever been treated for or been told you have any of the following...

Condition	Yes	No
Angina		
High Blood Pressure		
Heart Failure		
Heart Attack		
High Cholesterol		
Heart Disease		
Pacemaker		
Peripheral Vascular Disease		
Migraines		
Kidney Stones		
Kidney Disease		
Hepatitis B		
Hepatitis C		
Cancer Type: ___________________		
Osteoporosis		
Asthma		
COPD		
Emphysema		
Stroke/TIA		
Seizure		
Sleep Apnea		

Condition	Yes	No
Seasonal Allergies		
Bleeding Disorder		
Blood Clots		
Anemia		
Diabetes		
Arthritis		
Lupus		
Fibromyalgia		
Liver Disease		
Chronic Constipation		
Acid Reflux/GERD		
Colon Polyps		
Depression		
Anxiety		
Drug Abuse		
Alzheimer's/Dementia		
Thyroid Disease		
Glaucoma		
Macular Degeneration		
Genetic Disorder		
Other: _____________________________		

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SURGERIES: (Please include date)

☐ Appendectomy (Date:__________)
☐ Gallbladder Removal (Date:__________)
☐ Hip Replacement - ☐ Right ☐ Left (Date:__________)
☐ Hysterectomy (Date:__________)
☐ Cataracts - ☐ Right ☐ Left (Date:__________)
☐ Knee Replacement - ☐ Right ☐ Left (Date:__________)
☐ Stents (Date:__________)
☐ Other: ___________________________

HOSPITALIZATIONS:

(1) ____
(2) ____
(3) ____
(4) ____
(5) ____
(6) ____
(7) ____
(8) ____

INFECTIOUS DISEASES: Have you ever been treated for or been told you have any of the following...

	Yes	No			Yes	No	
Hepatitis	☐	☐		HIV/AIDS	☐	☐	
Frequent UTIs	☐	☐		Tuberculosis	☐	☐	
MRSA	☐	☐	If yes, where? __________	VRE	☐	☐	If yes, where? ____________

HEALTH MAINTENANCE:

Lipid (cholesterol) ☐ Yes ☐No Date: _______ Abnormal? ☐ Yes ☐No
Colonoscopy ☐ Yes ☐No Date:________ Abnormal? ☐ Yes ☐No Were any polyps removed? ☐ Yes ☐No
Mammogram ☐ Yes ☐No Date :_______ Ever had an abnormal result? ☐ Yes ☐No If so, when?____________
Pap Smear ☐ Yes ☐No Date:________ Ever had an abnormal result? ☐ Yes ☐No If so, when? ____________
Dexascan /Bone scan ☐ Yes ☐No Date:_____ Abnormal? ☐ Yes ☐No
PSA (prostate) ☐ Yes ☐No Date:________ Abnormal? ☐ Yes ☐No

VACCINATION HISTORY: (Please provide date of last vaccination)

Tetanus: ______ Tuberculin Skin Test: _______ Pneumonia: _______ Influenza: _______ Shingles:_______

ALLERGIES: (please list type of allergies and describe the reaction you experienced)

(1)____________________ Reaction: _______________
(2)____________________ Reaction: _______________
(3)____________________ Reaction: _______________
(4)____________________ Reaction: _______________
(5)____________________ Reaction: _______________
(6)____________________ Reaction: _______________
(7)____________________ Reaction: _______________
(8)____________________ Reaction: _______________

SOCIAL HISTORY:

Marital Status:
☐ Married ☐ Single ☐ Divorced ☐Widowed ☐ Significant Other

Highest Level of Education:
☐ _______ Grade ☐ High School ☐ Some College ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate

Occupation:
Work Status: ☐ Retired ☐ Full Time ☐ Disabled ☐ Unemployed
Occupation: ____

Living Arrangements:
☐ Alone ☐ With Spouse ☐ With Spouse and Children ☐ With Children ☐ With Father ☐ With Mother ☐ With Parents ☐ With Guardian

Travel:
Have you traveled outside the USA in the last year? ☐ Yes ☐ No If yes, where?___________________________________

Tobacco Use:
☐ Non-Smoker (Never Smoked) ☐ Ex-Smoker (Year Quit? _________) ☐ Current Smoker (Packs per day? _______)

Alcohol Use:
☐ Never ☐ Occasional (how often?___________) ☐ Frequent (# of drinks/week? _____)
Is your alcohol use a concern for you or others? ☐ Yes ☐No

Caffeine Use:
How much caffeine do you consume each day? ____

Drug Use:
Do you use any recreational drugs? ☐ Yes ☐No If yes, what types? ____

Exercise Frequency
☐ Never ☐ 2-3 times/week ☐ 4-5 times/week ☐ Daily
How long does your work-out usually last? _________ What types of exercises do you perform? ____________________

WOMAN'S HEALTH HISTORY:

Age at onset of menstruation: _____ Date of last period: __________ Age of menopause: __________
Could you be pregnant? ☐ Yes ☐No Menstrual cycle: _____ days Usual duration of flow: ______ days
Cycle: ☐ Regular ☐Irregular Flow: ☐ Heavy ☐ Medium ☐ Light Cramps: ☐ Severe ☐ Mild ☐ None
Pregnancies: How many? ____ Children born alive? ____ Stillbirths? _____ Abortions? _____ Miscarriages? _____

REVIEW OF SYSTEMS: (Please check any symptom you are currently experiencing)

Constitutional
_____ Recent fevers
_____ Night sweats
_____ Unexplained weight loss
_____ Unexplained weight gain
_____ Unexplained fatigue
_____ Unexplained weakness
Eyes
_____ Change in vision
Ears/Nose/Throat/Mouth
_____ Difficulty hearing
_____ Ringing in ears
_____ Hay fever
_____ Allergies
_____ Persistent congestion
_____ Trouble swallowing
Cardiovascular
_____ Chest pain
_____ Chest pressure
_____ Palpitations
_____ Short of breath with exertion
Respiratory
_____ Cough
_____ Wheeze
_____ Coughing up blood
_____ Coughing up mucus
Musculoskeletal
_____ Muscle pain
_____ Joint pain
_____ Recent back pain
Skin
_____ Rash
_____ New mole
_____ Change in mole
Blood/Lymphatic
_____ Unexplained lumps
_____ Easy bruising
_____ Easy bleeding
Breast
_____ Breast lump
_____ Nipple discharge
Gastrointestinal
_____ Recent heartburn/reflux
_____Blood in stool
_____ Change in bowel movement
_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Frequent constipation
Genitourinary
_____ Painful urination
_____ Bloody urination
_____ Leaking urine
_____ Frequent nighttime urination
_____ Discharge from penis or vagina
_____ Concerns with sexual functions
Neurological
_____ Headaches
_____ Memory loss
_____ Fainting
Psychiatric
_____ Anxiety
_____ Stress
_____ Sleeping problems
_____ Unusual sadness
_____ Unusual crying
Endocrine
_____ Cold intolerance
_____ Heat intolerance
_____ Increased thirst
_____ Increased appetite
Other Symptoms/Concerns
____
____
____

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FAMILY HISTORY: Indicate which relative has had the following diseases

☐ **Adopted, unknown family history**

Disease	**Mother**	**Father**	**Sister(s)**	**Brother(s)**	**Mom's Mom**	**Mom's Dad**	**Dad's Mom**	**Dad's Dad**	**Other Relative**	**Comments**
No significant history known										
High Blood Pressure										
High Cholesterol										
Heart Disease										
Migraine Headaches										
Kidney Failure										
Kidney Stones										
Hepatitis B										
Hepatitis C										
Cancer (Breast)										
Cancer (Colon)										
Cancer (Ovarian)										
Cancer (Prostate)										
Osteoporosis										
Asthma										
Emphysema										
Rheumatoid Arthritis										
Bleeding/Clotting Disorder										
Diabetes										
Lupus										
Colon Polyp										
Depression										
Alcoholism										
Alzheimer's										
Drug Abuse										
Thyroid Disease										
Glaucoma										
Macular Degeneration										
Genetic Disorder										
Hip Fracture										
Other (please list)										

MEDICATIONS: (Please list all medications that you are now taking, strength and how often you take each)

Medication: ________________________________ Strength:________________ Frequency: _________________________

Medication: ________________________________ Strength:________________ Frequency: _________________________

Medication: ________________________________ Strength:________________ Frequency: _________________________

Medication: ________________________________ Strength:________________ Frequency: _________________________

Medication: ________________________________ Strength:________________ Frequency: _________________________

Medication: ________________________________ Strength:________________ Frequency: _________________________

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Medication: ________________________________ Strength:________________ Frequency: _________________________

Medication: ________________________________ Strength:________________ Frequency: _________________________

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Patient Signature: ____ Date: _________________________

Reviewed by: ____ Date: _________________________