

**Internal Medicine History Form**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Single  Divorced  
 Married  Widow (er)

Address \_\_\_\_\_ Religion \_\_\_\_\_

Occupation \_\_\_\_\_ Previous Occupations \_\_\_\_\_ Occupation of Spouse \_\_\_\_\_

Birthplace \_\_\_\_\_ List all States or Countries in which you have lived \_\_\_\_\_

Education: Please check the last grade you completed

Grade	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
High School	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
College	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Post Grad. Degrees	_____ yrs.			

Have you traveled outside the USA in the last year? \_\_\_\_\_ Where? \_\_\_\_\_

Reason for today's appointment: \_\_\_\_\_

Were you referred to the clinic? \_\_\_\_\_ If so, by whom (name and address)? \_\_\_\_\_

**Family History:**

	Age	Health	Age at Death	If deceased cause
<b>Father</b>				
<b>Mother</b>				
<b>Brothers/Sisters</b>				
1.				
2.				
3.				
4.				
<b>Husband/Wife</b>				
<b>Son or Daughter</b>				
1.				
2.				
3.				
4.				
5.				
6.				

Do you have any blood relatives who have any of the following conditions?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> cancer (type___)    | <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> diabetes        | <input type="checkbox"/> Heart Trouble  |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> stroke        | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> mental illness |
| <input type="checkbox"/> suicide             | <input type="checkbox"/> birth defects | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Alcoholism     |

**Personal History (Please check all that apply):**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> measles or German Measles          | <input type="checkbox"/> Chicken pox or mumps            | <input type="checkbox"/> Whooping cough              |
| <input type="checkbox"/> Scarlet fever or Scarletina        | <input type="checkbox"/> Migraine headaches              | <input type="checkbox"/> Stroke or paralysis         |
| <input type="checkbox"/> blindness (even temporary)         | <input type="checkbox"/> seizures or epilepsy            | <input type="checkbox"/> Meningitis or polio         |
| <input type="checkbox"/> pneumonia or pleurisy              | <input type="checkbox"/> tuberculosis (TB)               | <input type="checkbox"/> asthma                      |
| <input type="checkbox"/> Influenza or flu                   | <input type="checkbox"/> Hayfever                        | <input type="checkbox"/> Hives or eczema             |
| <input type="checkbox"/> heart attack                       | <input type="checkbox"/> Angina                          | <input type="checkbox"/> heart failure               |
| <input type="checkbox"/> Rheumatic fever or heart murmur    | <input type="checkbox"/> high blood pressure             | <input type="checkbox"/> high blood pressure         |
| <input type="checkbox"/> high cholesterol                   | <input type="checkbox"/> diabetes                        | <input type="checkbox"/> Ulcers (stomach/intestinal) |
| <input type="checkbox"/> hepatitis                          | <input type="checkbox"/> gallbladder disease             | <input type="checkbox"/> Hiatus hernia               |
| <input type="checkbox"/> Diverticulosis                     | <input type="checkbox"/> Kidney/urinary tract infections | <input type="checkbox"/> Venereal Disease            |
| <input type="checkbox"/> Gonorrhoea or Syphilis             | <input type="checkbox"/> Arthritis or Rheumatism         | <input type="checkbox"/> Bursitis, Sciatica, Lumbago |
| <input type="checkbox"/> Neuritis or Neuralgia              | <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Unusual bleeding/bruising   |
| <input type="checkbox"/> Poisoning (food, chemicals, drugs) | <input type="checkbox"/> Thyroid Disease or Goiter       | <input type="checkbox"/> X-ray Therapy or Radiation  |
| <input type="checkbox"/> Nervous Breakdown                  | <input type="checkbox"/> Severe Depression               | <input type="checkbox"/> Frequent sore throats       |
| <input type="checkbox"/> Frequent infections                | <input type="checkbox"/> Any other Disease               |  |

**Have you ever been immunized for:**

- |                    |     |    |             |
|--------------------|-----|----|-------------|
| Diphtheria.....    | Yes | No | when? _____ |
| Tetanus.....       | Yes | No | when? _____ |
| Polio.....         | Yes | No | when? _____ |
| German Measles.... | Yes | No | when? _____ |
| Pneumonia.....     | Yes | No | when? _____ |
| Influenza.....     | Yes | No | when? _____ |
| Measles.....       | Yes | No | when? _____ |
| Whooping Cough.... | Yes | No | when? _____ |

**Have you ever had a skin test for TB (tuberculosis)?** \_\_\_\_\_ **When?** \_\_\_\_\_

**ALLERGIES (Are you allergic to):**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Latex                                | <input type="checkbox"/> Penicillin or Keflin  | <input type="checkbox"/> Sulfa              |
| <input type="checkbox"/> Erythromycin or Tetracycline         | <input type="checkbox"/> Other antibiotics     | <input type="checkbox"/> Aspirin or Tylenol |
| <input type="checkbox"/> Codeine or Morphine or Demerol       | <input type="checkbox"/> other pain medication | <input type="checkbox"/> Valium or Librium  |
| <input type="checkbox"/> Phenobarbital                        | <input type="checkbox"/> Dalmane or Seconal    | <input type="checkbox"/> other tranquilizer |
| <input type="checkbox"/> Iodine, Merthiolate or Mercurochrome | <input type="checkbox"/> Betadine or pHisoHex  | <input type="checkbox"/> Antihistamines     |
| <input type="checkbox"/> any other drug                       | <input type="checkbox"/> any food              | <input type="checkbox"/> Adhesive tape      |

- Cosmetics or perfume
- Nail polish
- Any other immunizations
- Any other serums

**INJURIES (have you had any):**

- Broken bones
- Sprains or dislocations
- Lacerations (Extensive)
- Concussion or head injury
- Ever been knocked out
- Whiplash

**TRANSFUSIONS (have you had any):**

- Blood or Plasma transfusion

**WEIGHT:**

Now \_\_\_\_\_

One Year Ago \_\_\_\_\_

Maximum \_\_\_\_\_ (year \_\_\_\_\_)

**HOSPITALIZATIONS:**

**Surgical Hospitalizations**

- 1. Tonsillectomy  Yes  No
- 2. Appendectomy  Yes  No
- 3. Any other surgery (please list)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HOSPITALIZATIONS other than for surgery (please list):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Habits: Do you**

- 1. Sleep well?.....Yes No
- 2. Use alcoholic beverages?.....Yes No
- Every Day.....Yes No
- 3. Smoke? .....Yes No
- How much? \_\_\_\_\_
- 4. Exercise enough?.....Yes No
- 5. Is your diet well balanced? .....Yes No

**MEDICATIONS:** List any drug or medication that you take.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WOMEN ONLY:**

1. Age at onset of menstruation \_\_\_\_\_

2. Date of last period \_\_\_\_\_

3. Is it possible that you may be pregnant?                      Yes      No

4. Menstrual cycle \_\_\_\_\_ days (from start to start)

5. Cycle                       regular                       irregular

6. Usual duration of flow \_\_\_\_\_ days

7. Flow:                       Heavy                       Medium                       Light

8. Cramps                       Severe                       Mild                       None

9: Pregnancies:      How many? \_\_\_\_\_

                                 Children born alive? \_\_\_\_\_

                                 Stillbirths? \_\_\_\_\_

                                 Prematures? \_\_\_\_\_

                                 Cesarean sections? \_\_\_\_\_

                                 Miscarriages? \_\_\_\_\_

                                 Complications?      Yes      No

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date