INTERNAL MEDICINE AFFILIATES

Your Health Review

Welcome to **INTERNAL MEDICINE AFFILIATES1** Each of us has a unique medical history. Your history will help me to diagnose and treat your problems. We can review this in the examining room when we discuss the reasons for your visit. Because the information is important, Please place a (*) beside any questions you don't understand.

CURRENT INFORMATION Today's date_____/____/_____

Your Name____________________________________ Date of Birth____/____/____

Name you prefer to be called_________________________________ Age_______________

Street Address____

City_______________________________________ State_________ Zip____________

Phone Number: Day _ ( ) _________________ Cell_ ( ) _______________________

Preferred contact ( ) ____

PERSON TO CONTACT in an EMERGENCY Name_______________________________

Relationship to You_____________________ Phone__ ( ) _________________________

Pharmacy you normally use: ____

Insurance Plan___________________________ Policy Number________________________

Policy holder___________________________ Group Number ________________________

Second Insurance Plan____________________ Policy Number________________________

Policy holder___________________________ Group Number________________________

REASON FOR YOUR VISIT TODAY- Please include your major concern(s)

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PERSONAL HEALTH HABITS/LIGESTYLE

Exposure: Check any of the following to which you have frequently been exposed

☐ Chemicals ☐ Cleaning fluids ☐ oils ☐ fumes ☐ Smoke ☐ continuous loud noise

☐ Coal ☐ dust ☐ cement ☐ asbestos ☐ x-rays ☐ radioactive materials

Alcohol: ☐ Non-drinker ☐ Dink only rarely ☐ Drink Socially ☐ Drink some each day

If you drink:
- Have you ever felt the need to cut down on drinking? ☐ Yes ☐ No
- Have you ever felt annoyed by criticism of your deinking? ☐ Yes ☐ No
- Have you ever had guilty feelings about drinking? ☐ Yes ☐ No
- Have you ever had an eye-opener (a drink first thing in the morning) ☐ Yes ☐ No

Tobacco:
- ☐ Never a smoker
- ☐ Current smoker Number of packs a day? ______ Age you began smoking ___________
- ☐ Quit smoking How many years did you smoke? ________ Year that you quit______
- ☐ Chew tobacco or dip snuff

Caffeine: ☐ Coffee drinker...cups/day _____ ☐ Tea/caffeine-contain sodas..Cups/day ______

Safety:
- ☐ Do you wear seat belts in a car/truck? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never
- ☐ Have you ever been a victim of physical abuse? ☐ Yes ☐ No

Exercise: ☐ No regular exercise ☐ Regular exercise…type of exercise__________________

PREVENTIVE HEALTH TESTS (Update)

(List year, location, result of most recent test)

Chest X-Ray__________________________

EKG_________________________________

Mammogram__________________________

Pap Smear____________________________

Cholesterol___________________________

Colon Exam__________________________

Prostate Exam________________________

Bone Density _________________________

IMMUNIZATIONS

(Check the ones you have had) Year, if known

- ☐ Tetanus Shot ________
- ☐ Flu Shot ________
- ☐ Pneumovax (Pneumonia Shot) _______
- ☐ Hepatitis B Vaccination (3 Shots) _______
- ☐ TB Skin Test _______
- ☐ Have you ever had rubella (German measles)?
- ☐ Have you had rubella vaccine? _______
- ☐ Have had Shingles? _ _____
- ☐ Have had COVID Vaccine _______

Which one?

☐ Pfizer ☐ Moderna ☐ Johnson & Johnson

REVIEW OF SYSTEMS Please mark with a check if you <u>currently</u> have problems with any of ***the following. If items NOT checked, your response is considered negative***

GENERAL:

☐ Sleeplessness ☐ Fatigue ☐ Fevers ☐ Weight gain ☐ Loss of appetite
☐ Excessive sleep ☐ Passing out ☐ Night sweats ☐ Weight loss

SKIN:

☐ Rash ☐ Dryness ☐ Itching ☐ Lumps/warts or mole changes
☐ Bruises ☐ Nail problems ☐ Hair problems ☐ Varicose vein

HEAD-EYES-EARS-NOSE-THROAT:

☐ Wear glasses ☐ Wear contacts ☐ Double vision ☐ Cataracts ☐ Glaucoma
☐ Hearing loss ☐ Wear hearing aid ☐ Ringing in ears ☐ Ear infection ☐ Ears clogged
☐ Dental/gum problems ☐ TMJ syndrome ☐ Wear dentures ☐ Nasal Drip ☐ Nasal Polyps
☐ Headaches ☐ Dizziness ☐ Sinus Disorder ☐ Hoarseness

BLOOD:

☐ Anemia ☐ Difficulty clotting ☐ Easy Bruising ☐ Sickle cell ☐ Thalassemia ☐ Other

NODES AND GLANDS:

☐ Swollen/Painful glands ☐ Excessive thirst ☐ Heat intolerance ☐ Overactive thyroids
☐ Diabetes ☐ Excessive urination ☐ Cold intolerance ☐ Underactive thyroid

BREASTS:

☐ Lumps ☐ Deformity ☐ Pain prior to menstruation
☐ Cysts ☐ Nipple Discharge ☐ Other ________________________________

LUNGS:

☐ Asthma ☐ Emphysema ☐ Bronchitis ☐ Shortness of breath
☐ Pneumonia ☐ Pleurisy ☐ Chronic cough ☐ Shortness of breath -with exercise
☐ TB Hyperventilation ☐ Coughing blood ☐ Shortness of breath -lying down

CARDIOVASCULAR:

☐ Heart attack ☐ Heart surgery ☐ Rheumatic fever ☐ Chest discomfort at rest ☐ High blood pressure
☐ Heart murmur ☐ Chest ☐ Discomfort with exertion ☐ \Irregular pulse (skipped beat)
☐ Heart valve Problem ☐ Angina pectoris ☐ Leg pain with walking ☐ Swelling ankles
☐ Phlebitis or blood clot ☐ Other ________________________

Have you ever had an exercise test (cardiac stress test)? ________________Year and result__________________

GASTROINTESTINAL:

☐ Difficulty swallowing ☐ Heartburn ☐ Blood in stool ☐ Hiatal hernia ☐ Colitis ☐ Hemorrhoids
☐ Abdominal pain ☐ Diarrhea ☐ Gallbladder disease ☐ Ulcer ☐ Hernia ☐ Hepatitis
☐ Constipation….Do you take anything for constipation? ____________________________

GENITO-URINARY:

☐ Kidney/Bladder infection ☐ Loss of bladder control (incontinence) ☐ Blood in urine

☐ Pain or burning with urination ☐ Increased frequency of urination ☐ Kidney stone

☐ Awakening at night to urinate ☐ Other: ________________________

MEN:

☐ Difficulty starting to urinate ☐ Discharge from penis

☐ Difficulty urinating steady streams ☐ Dribbling after urination

☐ Feeling of incomplete bladder emptying ☐ Prostate condition

☐ Venereal or sexually transmitted disease ☐ Loss of sex drive

☐ Difficulty getting an erection ☐ Other: ____________________

WOMEN:

Age at first period ___________ Date last normal menstrual period began? ________________________

Periods: ☐ Regular ☐ Irregular Lasting ________days ☐ Spotting between periods

Average frequency: every _____days ☐ Heavy periods ☐ Passage of clots

Do you use any type of birth control? ______ What type? ____________________________________

Have you gone through menopause? _______ Age of menopause _______________________________

☐ Hysterectomy… When? ___________ ☐ Hormone treatment after hysterectomy or menopause

☐ Abnormal bleeding from vagina ☐ Pelvic inflammatory ☐ Yeast infections

☐ Venereal or sexually transmitted disease ☐ Pain with sexual intercourse

☐ Loss of sex drive/other sexual difficulties

Number of pregnancies ___________ Number of live births: __________________________________

Number of miscarriages/abortions___________ Other: _____________________________________

MUSCULOSKELETAL:

☐ Arthritis ☐ Muscle Weakness ☐ Difficulty walking ☐ Gout

☐ Broken bones….which ____

NEUROLOGICAL:

☐ Seizures (epilepsy) ☐ Memory loss ☐ Depression ☐ Loss of coordination ☐ Numbness ☐ Loss of balance

☐ Anxiety

Patient Signature _____________________________________ Date: ____________

Thank you for taking the time to fill out this medical history: Please return this form as soon as possible or bring it with you on your next planned visit.

Physician Signature ____________________________________ Date: ________________________________