INTERNAL MEDICINE AFFILIATES

Your Health Review

Patient Name ______________________________
Date of Birth______________________________
Medial Record number________________________
Date of service_____________________________
Physician_________________________________

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_ ( ) _______________ Email__________________________

Preferred contact ( ) ____

☐ Male ☐ Female **Social Security** # _____-____-_____ Last Grade Completed ______________________

☐ Single ☐ Married…When? ________ ☐ Divorced…When? ____________ ☐ Widowed…When? _______

Occupation ____ Retired….When? ___________________

Hobbies/Interests ____

Religious Denomination (optional) ____

PERSON TO CONTACT in an EMERGENCY Name________________________________

Relationship to You_____________________ Phone__ ( ) _________________________

Pharmacy you normally use: ____

Previous physicians you have seen ____

Last complete exam __/__/__ Physician ____

Were you referred to our clinic? _________________ If so, by whom? ____________________________

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)

____

____

Please List any ***SERIOUS ILLNESSES*** you have had in the past or have now:

(High blood pressure, diabetes, heart problems, stroke, kidney problems, cancer, liver problems, etc.)

YEAR OF ONSET ILLNESS CONDITION AT PRESENT

____

____

Pleas list all surgical PROCEDURES (operations) that you have had:

(Appendectomy, hysterectomy, gallbladder, tonsillectomy, heart surgery, cataract surgery, etc)

YEAR	SURGICAL PROCEDURE	REASON	SURGEON

MEDICATION ALLERGIES List medications that you are allergic to and type of reaction you had

____

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 ☐ Drink 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_______________________

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 you had a COVID Vaccine _______

☐ Pfizer ☐ Moderna ☐ Johnson& Johnson

For each family member, please note his/her age and any major health problems (diabetes, cancer, high blood pressure, etc) If deceased note age and cause of death

HEALTH OF YOUR FAMILY

	Good	Poor	Died	
Father (natural, biological)	☐	☐	☐	____________
Mother (natural, biological)	☐	☐	☐	____________
Brothers/Sister____________	☐	☐	☐	____________
____________	☐	☐	☐	____________
____________	☐	☐	☐	____________
Spouse____________	☐	☐	☐	____________
Children____________	☐	☐	☐	____________

Please note any major diseases in your other close blood relatives (grandparents, aunt/uncles)______________________

____

____

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: ____________________________