

**PATIENT HISTORY RECORD
FACULTY INTERNAL MEDICINE**

Date of Appt: _____

Name: _____ Date of Birth: _____
Last First Middle

The information you provide today is very important in regards to your healthcare. Please answer the following questions carefully and thoroughly to the best of your ability.

Reason for today's visit (list in order of importance to you): _____

Other physicians you are currently seeing:

Do you see a Chiropractor, Massage therapist, Therapist, Faith healer, Practitioner of homeopathy and/or others?
Please list: _____

Allergies: _____

PAST MEDICAL HISTORY:

Do you have or have you ever had?

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anemia (low blood) | <input type="checkbox"/> Breast masses |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Prostate disease |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Blood clots | <input type="checkbox"/> HIV testing |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Splendectomy | <input type="checkbox"/> HIV risk factors |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma/allergy | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> DEXA (Date __/__/__) |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Pneumonia or TB | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Colon disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stomach disease | <input type="checkbox"/> Nervous/anxiety problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Liver disease/hepatitis | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Colonoscopy (Date __/__/__) | <input type="checkbox"/> Cancer | |

Patient Name: _____

Hospitalizations:

Please list hospitalizations and dates for medical and surgical problems including childbirth:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Vaccinations:

When did you have last tetanus shot? _____

Do you get a yearly flu shot?	___ Yes	___ No	Yr. _____
Have you had the pneumonia vaccine?	___ Yes	___ No	Yr. _____
Any exposure to TB?	___ Yes	___ No	
TB Skin test results:	___ Positive	___ Negative	Yr. _____
If born after 1956, have you received a second MMR vaccine?	___ Yes	___ No	Yr. _____
Hepatitis A vaccine (series of 2)	___ Yes	___ No	Yr. _____
Hepatitis B vaccine (series of 3)	___ Yes	___ No	Yr. _____
Chickenpox or vaccine	___ Yes	___ No	Yr. _____
Shingles vaccine	___ Yes	___ No	Yr. _____
HPV (Gardasil) vaccine	___ Yes	___ No	Yr. _____

Social History:

Occupation _____ Employer _____

Education (Highest level completed) _____ Marital status ___(M)___(W)___(D)___(S)

Spouse Name _____ His/Her employer _____

Religious preference if any _____

Smoking:

Do you currently smoke? ___Yes ___No	Have you ever smoked? ___Yes ___No
Age started _____ Age stopped _____	How many packs per day? _____
Interested in stopping? ___Yes ___No	Dip/Snuff/Chew? ___Yes ___No

Alcohol:

Do you drink alcohol? ___Yes ___No	How many drinks/week? _____
Do you think you have a drinking problem?	___ Yes ___ No
Do you feel the need to cut down?	___Yes ___No

Drugs:

Do you presently use drugs? ___Yes ___No

Have you ever used drugs (eg: cocaine, marijuana, heroin)? ___Yes ___No

Patient Name: _____

Wellness practices:

Do you examine your skin? __Yes __No

Do you use sun protection? __Yes __No

Do you use a seat belt? __Yes __No

Do you currently exercise? __Yes __No

Type of exercise _____ Frequency and duration of exercise _____

Hobbies/recreation: _____

Have you been hurt or threatened by someone? __ Yes __ No

If yes, please explain: _____

Family history:

Father: Current age (if living) _____

Illnesses _____

Age at death _____

Cause of death _____

Mother: Current age (if living) _____

Illnesses _____

Age of death _____

Cause of death _____

Siblings: No. Brothers _____

No. Sisters _____

Age range _____

Illnesses _____

Age at death _____ Cause of death _____

Do you have children? __Yes __No Age(s): _____ Any health problems? _____

Have any other relatives had any of the following (include grandparents, aunts, uncles, but exclude relatives by marriage)

Diabetes

Colon cancer

Stroke (prior to age 60)

Heart attach (prior to age 60)

Kidney disease

Other cancer _____

Prostate cancer

Ovarian cancer

Other _____

Breast disease

Thyroid disease

Patient Name: _____

REVIEW OF SYSTEMS:

Have you had any of the following symptoms in the past four months?

- | | | |
|--|--|--|
| <input type="checkbox"/> Weight Loss/gain | <input type="checkbox"/> Joint swelling or pain | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chest pain/pressure/heaviness | <input type="checkbox"/> Face pain |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Stomach/abdominal pain | <input type="checkbox"/> Loss of strength or speech |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Depression/tearfulness |
| <input type="checkbox"/> Change in eyesight | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Black or bloody bowel | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Ears ringing/hearing loss | <input type="checkbox"/> Heartburn/indigestion | <input type="checkbox"/> Extra heart beats or racing heart |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty swallowing/food sticking | <input type="checkbox"/> Unusual bruising or bleeding |
| <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Yellow eyes/skin | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Nasal congestion/drainage | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Difficulty urinating/incontinent | <input type="checkbox"/> Leg cramps |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Changes in wart/mole/skin growth |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Excessive tiredness | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Backache | | |

Date and location of your most recent hospital admission: _____

Date and location of your most recent ER visit: _____

Date and location of your most recent doctor office visit: _____

Special ambulatory needs or limitations: cane, walker, wheelchair, other: _____

Physical disabilities-please list: _____

Hearing impairment? __Yes __No If yes, please describe: _____

Vision impairment? __Yes __ No If yes, please describe: _____

Last complete eye exam (date and provider): _____

Do you have trouble chewing or swallowing? __Yes __No Explain: _____

Dentures (including partials)? __Yes __No

How many meals a day do you eat on average? _____

Do you need assistance with meals? __Yes __No If yes, please describe: _____

Patient Name: _____

PLEASE SKIP TO BOTTOM AND SIGN IF YOU ARE MALE

Menstrual History (Women):

Date of last pap/pelvic? _____ Where was this performed? _____

Have you ever had an abnormal pap smear? _____ If yes, when? _____

Date of last period? _____ Do you have irregular menstrual bleeding? _____

Do you have painful periods? _____ Do you have vaginal discharge? _____

Have you had bleeding after Menopause? _____

Number of pregnancies _____ Number of live births _____ Number of living children _____

Hysterectomy? _____ If yes, when? _____ Why? _____

Are ovaries still present? _____

Date of last mammogram _____ Do you perform monthly self-breast exams? _____

Do you have breast lumps/nipple discharge? _____

Name of caregiver and phone number: _____

Signature of patient or
responsible party

Relationship

Date

Reviewed by

Date