

**PATIENT HISTORY RECORD
FACULTY INTERNAL MEDICINE**

Name: _____ Date of Appt.: ____/____/____
Last First Middle

Home Phone: (____)____-____. Cell Phone: (____)____-____ Work Phone: (____)____-____

Address: _____ City: _____ ST: _____ Zip: _____

Social Security #: _____ Birth Date: _____ Age: _____

Referred by: _____

Pharmacy: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Relationship to you: _____ Address: _____

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: _____

Current prescription medications you are taking and dosage: _____

Current non-prescription medications including pain relievers, vitamins, herbs and any non-traditional medications:

Medication Allergies: _____

Other Allergies: _____

PAST MEDICAL HISTORY:

Patient Name: _____

Do you have or have you ever had?

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anemia (low blood) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Colonoscopy (Date ___/___/___) | <input type="checkbox"/> Breast masses |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Prostate disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Splenectomy | <input type="checkbox"/> HIV testing |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Asthma/allergy | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Emphysema | <input type="checkbox"/> DEXA (Date ___/___/___) |
| <input type="checkbox"/> Stomach disease | <input type="checkbox"/> Pneumonia or TB | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Liver disease/hepatitis | <input type="checkbox"/> Nervous/anxiety problems | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Colon Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Other _____ |

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

Vaccinations:

When did you last have a 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

Last TB skin test: _____

TB skin test results: __Positive __Negative

If born after 1956 have you received a 2nd MMR vaccine?
__Yes __No Yr. _____

Hepatitis B vaccine (series of 3) __Yes __No Yr. _____

Hepatitis A vaccine (series of 2) __Yes __No Yr. _____

Chickenpox or vaccine __Yes __No Yr. _____

Shingles vaccine __Yes __No Yr. _____

HPV (Gardasil) Vaccine __Yes __No Yr. _____

Patient Name _____

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

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

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 within the past year? _____ If yes, please explain: _____

At any time, has someone hit, kicked or otherwise hurt or frightened you?

Family history:

Father: Current age (if living) _____ Illnesses _____
Age at death _____ Cause of death _____

Mother: Current age (if living) _____ Illnesses _____
Age at 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 of your primary relatives had any of the following (include grandparents, aunts, uncles, but exclude relatives by marriage)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Breast disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Heart attack (prior to 60) | <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Stroke (prior to age 60) | <input type="checkbox"/> Other cancer | |

Patient Name: _____

REVIEW OF SYSTEMS:

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

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: _____

Do you have a Living Will/Durable Power of Attorney? __Yes __No If yes, please provide a copy for your chart.

Would you like information on Living Wills/Durable Power of Attorney? __Yes __No

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: _____

Name of caregiver and phone number: _____

Signature of patient or responsible party

Relationship

Date

Reviewed by

Date

Patient name: _____

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? _____

Revised (7/19/07)