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?

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

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. _____
If yes, which type: ___ Pneumococcal 23	___ Prevnar 13		
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 (Gardisil) 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
Age started____ Age stopped____
Interested in stopping? __Yes __No
Have you ever smoked? __Yes __No
How many packs per day? ____
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

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
- ☐ Heart attack (prior to age 60)
- ☐ Prostate cancer
- ☐ Breast disease
- ☐ Colon cancer
- ☐ Kidney disease
- ☐ Ovarian cancer
- ☐ Thyroid disease
- ☐ Stroke (prior to age 60)
- ☐ Other cancer _____
- ☐ Other _____

REVIEW OF SYSTEMS:

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

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

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

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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? _____

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Name of caregiver and phone number:_____

_____	_____	_____
Signature of patient or responsible party	Relationship	Date

_____	_____
Reviewed by	Date

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