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
- ☐ Splenectomy
- ☐ Asthma/allergy
- ☐ Emphysema/COPD
- ☐ Pneumonia or TB
- ☐ Glaucoma
- ☐ Nervous/anxiety problems
- ☐ Seizures
- ☐ Cancer
- ☐ Breast masses
- ☐ Prostate disease
- ☐ HIV screening (Date__/__/__)
- ☐ AIDS/HIV
- ☐ DEXA (Date__/__/__)
- ☐ Arthritis
- ☐ Depression
- ☐ Other _____
  _____

Patient Name: _____

Hospitalizations:

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

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

Please provide the *last* date(s) of the following:

Pneumococcal 23: __/___/___ Hep A vaccine: (1st) __/___/___ (2nd) ___/___/___
Prevnar 13 vaccine: __/___/___ Hep B vaccine: (1st) __/___/___ (2nd) ___/___/___ (3rd) ___/___/___
Flu vaccine: __/___/___ Gardisil vaccine: (1st) __/___/___ (2nd) ___/___/___ (3rd) ___/___/___
Tetanus vaccine: __/___/___ Shingles vaccine: (1st) __/___/___ (2nd) ___/___/___
MMR vaccine: (1st) __/___/___ (2nd) ___/___/___
COVID Vaccine: (1st) ___/___/___ (2nd) ___/___/___ Brand: _____

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*_____ Age range _____
Illnesses_____
Age at death _____ Cause of death_____

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 _____

Patient Name: _____

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: _____

Sex assigned at birth? __Male __Female __Intersex

Legal Sex (based on Govt. ID) __ Male __Female __ Non binary

Gender Identity? (Check all that apply) __ Male __ Female __ Non binary __ Transgender
__ Other: _____

Sexual orientation? _____

Have you ever had an abnormal pap smear? ___ If yes, when? _____ Date of last period _____

Date of last pap smear? ____/___/____

Do you have irregular menstrual bleeding? ___ Do you have painful periods? ____

Do you have vaginal discharge? ___ Have you bled after menopause? ___

Number of pregnancies ___ Number of live births___ Number of living children___

Hysterectomy? _____ If yes, When? _____ Why? _____

Are ovaries still present? ___ Do you perform monthly self-breast exams? __

Date of last mammogram? ___/___/____

Do you have breast lumps/nipple discharge? _____

Sexual History

Do you have known risks for HIV or other Sexually Transmitted Infection? _____

Are you sexually active?: __ Yes __ No If so, with: (circle all that apply) Men Women Both

Have you had multiple sexual partners in the last 6 months? __ Yes __ No

Have you been treated for a Sexually Transmitted Infection in the past year: __ Yes __ No

Do you use condoms? __ Yes __ No Do you use a Birth Control Method? _____

****

_____ _____ _____
Signature of patient or responsible party | Relationship | Date

Name of caregiver and phone number:_____

_____ _____
Reviewed by | Date

Faculty Internal Medicine, PLLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex