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EAST METRO INTERNAL MEDICINE

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Medical History

Date: _____

Name _____ Age _____ Birthdate ____/____/____
Address _____ Sex: ❑ M ❑ F
_____ Home Phone _____
_____ Work Phone _____
Occupation _____ Emergency Contact _____
Phone CELL _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If married, spouse's name _____
Children's Names and ages _____

Allergies to Medications, X-Ray Dyes, or Other Substances ❑ No ❑ Yes

(If yes, please list name of medicine and type of reaction)

_____ _____
_____ _____

Past Medical History & Review of Systems

Please circle if **you** have had broblems with or are presently complaining of any of the following:

1.	Diabetes/Sugar	19.	Hay fever	37.	Skin diseases
2.	Cancer	20.	Rheumatic fever	38.	Veneral diseases
3.	Head or Neck Radiation	21.	Sinus trouble	39.	HIV or high risk
4.	High blood pressure	22.	Abdominal discomfort	40.	Frequent urination
5.	Frequent nose bleeds	23.	Indigestion	41.	Kidney stones
6.	Heart disease	24.	Ulcers	42.	Kidney disease
7.	Heart murmur	25.	Nausea	43.	Headache
8.	Palpitations	26.	Vomiting	44.	Arthritis
9.	Chest pain/chest tightness	27.	Constipation	45.	Gout
10.	Shortness of breath	28.	Diarrhea	46.	Lower back problems
11.	Swollen ankles	29.	Blood in stool	47.	Blood disorders
12.	Double/blurred vision	30.	Hemorroids	48.	Anemia
13.	Lightheadedness	31.	Recent loss of appetite	49.	Anxiety
14.	Persistent cough	32.	Unexplained weight gain/loss	50.	Depression
15.	Asthma	33.	Colitis	51.	Alcohol abuse
16.	Bronchitis	34.	Hepatitis or jaundice	52.	Drug abuse
17.	Pneumonia	35.	Gall bladder disease	53.	_____
18.	T.B.	36.	Thyroid disease	54.	_____

_____
_____

Gynecologic and Obstetric History

Age at onset of periods: _____ Frequency: _____ Length of period: _____ Date of last menstrual period: _____
Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged or abnormal bleeding: ❑ No ❑ Yes (Please describe): _____
Leakage of urine: ❑ No ❑ Yes (Please describe): _____
Pelvic pain: ❑ No ❑ Yes (Please describe): _____
Abnormal discharge: ❑ No ❑ Yes (Please describe): _____
History of abnormal Pap smear: ❑ No ❑ Yes (Please describe): _____

Pregnant ❑ No ❑ Yes Planning Pregnancy: ❑ No ❑ Yes
Sexually Active ❑ No ❑ Yes Use birth control: ❑ No ❑ Yes
Have passed menopause: ❑ No ❑ Yes Taking Hormones: ❑ No ❑ Yes

Patient Name _____ **Date:** ____/____/____

Please List and Supply the Dates of:

Operations: _____ _____

_____ _____

Hospitalizations other than for surgery: _____

_____ _____

Immunization history – have you had: Pneumovax immunization? ❑ No ❑ Yes When? _____

Hepatitis B? ❑ No ❑ Yes When? _____ Flu immunization? ❑ No ❑ Yes When? _____

Other? ❑ No ❑ Yes When? _____ Tetanus immunization? ❑ No ❑ Yes When? _____

When was your last:

Pap smear? _____ Mammogram? _____ Breast exam? _____

Cholesterol check? _____ EKG? _____ Chest x-ray? _____

Stool check for blood? _____ Prostate exam? _____ Colon screen? _____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Approx. age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other:		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug name	Dose	Drug name	Dose

Prevention

Do you smoke? ❑ No ❑ Yes If yes, how many packs per day?_____How long? _____ When stopped? _____

Do you drink alcoholic beverages? ❑ No ❑ Yes If yes, type & amount? _____How long? When stopped?

Do you drink coffee? ❑ No ❑ Yes If yes, how many cups per day?_____

Do you drink tea? ❑ No ❑ Yes If yes, how many cups per day?_____

Do you use drugs? (marijuana, cocaine, crack, etc.) ❑ No ❑ Yes If yes, explain: _____

_____How long? _____ When stopped? _____

Have you ever engaged in any activity which has put you at risk of getting AIDS? ❑ No ❑ Yes If yes, explain: _____

_____

Do you wish to be tested for AIDS? ❑ No ❑ Yes

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ❑ No ❑ Yes If yes, explain: _____

_____

Do you have a "living will"? ❑ No ❑ Yes

Do you have a donor card? ❑ No ❑ Yes

What is your exercise routine? _____

Method of birth control? _____