Center for Internal Medicine
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MEDICAL HISTORY

Today's Date: _____ Gender: ❑ F ❑ M

Patient Name:_____ DOB: _____ Height _____ Weight _____

Vital Signs: BP_____ T _____ HR _____ RR _____ POx _____

Reason for today's visit?: _____ Date of last physical exam: _____
(Signs and Symptoms)

CURRENT MEDICATIONS: (includes non-prescription products): _____ , _____,
(Drug name/Dose/Frequency if available)

_____, _____, _____, _____.

ALLERGIES (Includes drugs, food, insects, etc).: _____
(Allergy name/Reactions if available)

_____

SURGERY AND PROCEDURES: _____
(Procedure/Year if available)

_____

CONDITIONS AND MEDICAL HISTORY:

Have you had any of the following conditions in the past?
If so, please explain.

- ❑ Abnormal weight gain/loss _____
- ❑ Alzheimer's Disease/Dementia/Memory Loss_____
- ❑ Dizziness/Numbness/Weakness _____
- ❑ Epilepsy/Seizures _____
- ❑ Fainting/Light-headedness_____
- ❑ Headache/Blurred Vision _____
- ❑ Stroke _____
- ❑ Sinus Infection _____
- ❑ Asthma/Allergies _____
- ❑ Bronchitis _____
- ❑ Cough _____
- ❑ Emphysema _____
- ❑ Pneumonia _____
- ❑ Shortness of Breath (Dyspnea) _____
- ❑ Snoring _____
- ❑ Leg Swelling _____
- ❑ Congestive Heart Failure _____
- ❑ Coronary Artery Disease _____
- ❑ Heart Condition/Heart Disease _____
- ❑ High Blood Cholesterol _____
- ❑ High Blood Pressure _____
- ❑ Pain or Pressure in Chest _____
- ❑ Palpitations _____
- ❑ Stomach or Intestinal Problems _____
- ❑ Gastritis/Ulcers/Reflux _____
- ❑ Liver Problems/Hepatitis _____
- ❑ Kidney Disease/Excessive Urination _____
- ❑ Bladder/Kidney Infections _____
- ❑ Anemia/Bleeding/Abnormal Bruising _____
- ❑ Diabetes Type 1/Type 2 _____
- ❑ Increased Thirst _____
- ❑ Hypothyroidism _____
- ❑ Thyroid Problems _____
- ❑ Depression/Anxiety _____
- ❑ Sexual Dysfunction _____
- ❑ Breast Lumps/Menstrual Problems _____
- ❑ Skin Lesion _____
- ❑ Joint or Muscle Pain _____

CONDITIONS AND MEDICAL HISTORY (CONT.):

Cancer:
- ❑ Breast Cancer
- ❑ Colon/Rectal Cancer
- ❑ Lung Cancer
- ❑ Ovarian Cancer
- ❑ Prostate Cancer
- ❑ Skin Cancer
- ❑ Other_____ _____

FAMILY HISTORY:

Heart Disease	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Cancer	❑ Yes	❑ No

Other _____

IMMUNIZATIONS:

(Mark the year of last vaccine if known)

	YEAR
❑ Hepatitis A	_____
❑ Hepatitis B (Hep B)	_____
❑ Influenza	_____
❑ Pneumococcal vaccine	_____
❑ Tetanus and Diphtheria booster (Td)	_____

SCREENING TEST:

(Mark the year if known)

	YEAR
❑ Colonoscopy	_____
❑ Mammogram	_____
❑ Prostate Examination	_____
❑ Bone Densitometry	_____

HEALTH HABITS AND BEHAVIORS:

- ❑ Exercise (Days/Week): _____
- ❑ Stress Level: ❑ Mild ❑ Moderate ❑ High

(Check substances that you use and how often)

- ❑ Tobacco (Packs/Day) _____
- ❑ Alcohol (Drinks/Week): _____
- ❑ Street Drugs _____

I certified that the above information is correct to the best of my knowledge. I will not hold the doctor, ***Center for Internal Medicine*** or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient / Responsible Party Signature Date