INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Patient Name:_____ **Date of Birth:**_____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:_____

Other Concerns:_____

ALLERGIES:

List anything you are allergic to (medications, food, bee stings, etc.) and how each affects you:

	Allergy:	**Reaction**
1.	_____	_____
2.	_____	_____
3.	_____	_____

FAVORITE PHARMACY:_____

MEDICATIONS:

Please list all medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins/inhalers.

	Drug Name:	Strength:	Frequency Taken:
1.	_____		_____
2.	_____		
3.	_____		
4.	_____		
5.	_____		
6.	_____		
7.	_____		
8.	_____		
9.	_____		
10.	_____		

IMMUNIZATION HISTORY:

Immunizations and most recent date:

o	Chickenpox	Date:	o	Meningococcus	Date:
o	Flu Shot	Date:	o	MMR (Measles, Mumps, Rubella)	Date:
o	Gardasil/HPV	Date:	o	Pneumonia (Pneumovax)	Date:
o	Hepatitis A	Date:	o	Tdap (Tetanus and Pertussis)	Date:
o	Hepatitis B	Date:	o	Tetanus	Date:
			o	Zostavax (Shingles)	Date: __

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY:

Last PAP Smear Date: ❑ Abnormal

Last Mammogram Date: ❑ Abnormal

Age of first menstrual period:

Date of last menstrual period or age of menopause:

Number of pregnancies: Births:

Miscarriages: Abortions:

❑ Cesarean Sections If yes, then number of:

❑ Bleeding between periods

❑ Heavy periods

❑ Extreme menstrual pain

❑ Vaginal itching, burning, or discharge

❑ Wake in the night to go to the bathroom

❑ Hot flashes

❑ Breast Lump or nipple discharge

❑ Painful intercourse

❑ Sexually active
Current sexual partner is ❑M ❑F
Do you use condoms? ❑Yes ❑No
Other birth control method:

❑ Interested in being screened for STD's

PAST MEDICAL HISTORY:

Please check all that apply:

❑ Anxiety Disorder
❑ Arthritis
❑ Appendicitis
❑ Asthma
❑ Bleeding Disorder
❑ Blood Clots (or DVT)
❑ Cancer
Type:
❑ Coronary Artery Disease
❑ Diabetes – Insulin
❑ Diabetes – Non-Insulin
❑ Dialysis
❑ Diverticulosis/Diverticulitis
❑ Fibromyalgia
❑ Gallstones
❑ Gout
❑ Heart Attack
❑ Heartburn
❑ Heart Murmur
❑ Hiatal Hernia
❑ HIV or AIDS
❑ High Cholesterol
❑ High Blood Pressure
❑ Kidney Disease
❑ Kidney Stones
❑ Leg-Foot Ulcers
❑ Liver Disease
❑ Osteoporosis
❑ Pacemaker
❑ Peptic Ulcer Disease
❑ Pulmonary Embolism
❑ Stroke
❑ Thyroid Disorder
❑ Tuberculosis
❑ Other:

PAST SURGICAL HISTORY:

Surgery: Year:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

FAMILY HEALTH HISTORY:

Has anyone in your family been diagnosed with any of the following? :

❑ Cancer (if so, what type) ❑ Diabetes ❑ Heart Disease ❑ Hypertension

If you checked yes, please fill in the following:

Family Member:	Alive (Yes/No):	Age:	Diagnosis:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY:

Occupation: _____

Education: ❑ Less than 8th grade ❑ High school ❑ 2 year college ❑ 4 year college ❑ Post graduate

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Domestic Partner

Exercise Level: ❑ None ❑ Occasional ❑ Moderate ❑ High

Caffeine: ❑ None ❑ Occasional ❑ Moderate ❑ Heavy

cups/cans per day? _____

Alcohol: Do you drink alcohol? ❑ Yes ❑ No

If so, how often? ❑ Occasionally ❑ less than 3 times a week ❑ more than 3 times a week

How many drinks per week? _____

Tobacco: Do you use tobacco? ❑ Yes ❑ No

If not currently, have you ever used tobacco? ❑ Yes ❑ No

❑ Cigarettes ____ pks/day ❑ Chew ____ /day ❑ Cigars ____/day ❑ # of years____ ❑ year quit_____

Drugs: Do you currently use recreational or street drugs? ❑ Yes ❑ No

If yes, please list: _____

_____

_____