Partners In Internal Medicine

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PATIENT HISTORY

IF YOU CAN READ THIS FORM, PLEASE SIGN HERE: _____

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

Occupation: _____ **Type of Work:** _____

Family Medical History

Please check if any blood relative now has or has had any of the following conditions:

Condition:	Relation:	Condition:	Relation:
☐ Cancer – Type	_____	☐ Arthritis	_____
☐ Heart Attack	_____	☐ Asthma	_____
☐ Stroke	_____	☐ Depression / Att. Suicide	_____
☐ High Blood Pressure	_____	☐ Bleeding Problems	_____
☐ Diabetes	_____	☐ Other Illness	_____

Your Medical History

Prior Surgery: Operation	Year	Medical Illnesses / Injuries: Condition	Year

List All Medications You Take (including over – the – counter)

Medication:	Dose:	Times per Day:

Drug Allergies:

Medication:	Reaction:

Ongoing Medical Problems

Please check if you have any of the following conditions:

☐ Stroke	☐ Shortness of Breath	☐ Thyroid Condition
☐ Seizure	☐ High Blood Pressure	☐ Diabetes
☐ Headaches	☐ Heart Murmur	☐ Menstrual Problems
☐ Eye Disease	☐ Angina / Chest Pain	☐ Skin Cancer
☐ Visual Problems	☐ Palpitations	☐ Abnormal Moles
☐ Hearing Problem	☐ Abdominal Pain	☐ Blood Disorder
☐ Mouth Sores	☐ Ulcer	☐ Arthritis
☐ Difficulty Swallowing	☐ Bowel Problems	☐ Mental Illness
☐ Lung Disease	☐ Difficulty Urinating	☐ Depression
☐ Asthma	☐ Sexual Dysfunction	☐ Other _____

Do You Now or Have You Ever Consumed

☐ Cigarettes ☐ Current Smoker ☐ Quit Pkg. per day _____ # of Years _____

☐ Alcohol Drinks per week _____

☐ Coffee / Tea Cups per day _____

☐ Drugs (Marijuana, Cocaine, etc.) Type _____

The Date (year) You Last Had

Tetanus Shot _____

Hepatitis B Vaccine _____

Pneumonia Shot _____

TB Test _____

Do You…

Exercise? _____ Hours per week _____

Use a bicycle helmet? _____ Use a seat belt? _____

Have smoke detectors? _____ Know C.P.R? _____

For Women

Number of Pregnancies _____

Number of Births _____

Number of Abortions _____

Number of Miscarriages _____

Date of Last Menstrual Period _____

Using Birth Control? ☐ Yes – type _____ ☐ No

Year of Last:

PAP Test _____ ☐ Normal ☐ Abnormal

Breast Exam _____ ☐ Normal ☐ Abnormal

Mammogram _____ ☐ Normal ☐ Abnormal

Reviewed By:

_____ **M.D.** **Date** _____