Internal Medicine Associates

SOCIAL, FAMILY, & MEDICAL HISTORY

PATIENT NAME: _____ ***DATE OF BIRTH:*** _____ ***AGE:*** _____

MARITAL STATUS:

OCCUPATION: _____ ***HOBBIES:*** _____

TOBACCO USE: ☐ NONE ☐ YES SMOKE CHEW (PLEASE CIRCLE)
_____ QUIT DATE _____ YEARS _____ PACKS/DAY

ALCOHOL USE: ☐ NONE ☐ YES _____ DRINKS BEERS SHOTS (PLEASE CIRCLE)
HOW MANY?
PER DAY WEEK MONTH (PLEASE CIRCLE)

RECREATIONAL DRUG USE: ☐ NONE ☐ YES IF YES, PLEASE EXPLAIN:

FAMILY MEDICAL HISTORY:

(PLEASE CHECK ALL THOSE THAT APPLY TO PARENTS &/OR SIBLINGS)

☐ BLEEDING PROBLEMS ☐ CROHNS/COLITIS ☐ OTHER _____
☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ OTHER _____
☐ RESPIRATORY PROBLEMS ☐ HEART ATTACK ☐ OTHER _____
☐ CANCER *(PLEASE SPECIFY: TYPE _____; RELATIONSHIP: _____)*

PATIENT MEDICAL HISTORY:

SURGERIES:

(PLEASE CHECK ALL THAT APPLY TO YOURSELF)

EYE
☐ GLASSES/CONTACTS
☐ GLAUCOMA
☐ CATARACTS
☐ OTHER _____

EAR/NOSE/THROAT
☐ HEARING LOSS/RINGING
☐ SINUS PROBLEMS
☐ NOSE BLEEDS
☐ OTHER _____

CARDIOVASCULAR
☐ CHEST PAIN/PRESSURE
☐ SWELLING HANDS/FEET
☐ RAPID HEART RATE
☐ SKIPPED BEATS
☐ HIGH BLOOD PRESSURE
☐ STROKE
☐ PACEMAKER
☐ OTHER _____

RESPIRATORY
☐ SHORTNESS OF BREATH
☐ COUGH
☐ WHEEZING/ASTHMA
☐ COUGHING UP BLOOD
☐ EMPHYSEMA
☐ OTHER _____

GASTROENTEROLOGICAL
☐ NAUSEA/VOMITING
☐ ABDOMINAL PAIN
☐ RECTAL BLEEDING
☐ DIARRHEA
☐ CONSTIPATION
☐ WEIGHT LOSS/GAIN
☐ ULCERS
☐ SWALLOWING DIFFICULTY
☐ HEPATITIS ○A ○B ○C
☐ OTHER _____

UROLOGICAL
☐ BLOOD IN URINE
☐ KIDNEY STONES
☐ PROSTATE PROBLEMS
☐ BLADDER INFECTIONS
☐ OTHER _____

REPRODUCTIVE
☐ SEXUAL PROBLEMS
☐ OTHER _____

MUSCULOSKELETAL
☐ MUSCLE PAIN/CRAMPS
☐ JOINT SWELLING
☐ ARTHRITIS
☐ DIFFICULTY WALKING
☐ OTHER _____

ENDOCRINOLOGICAL
☐ THYROID DISEASE
☐ DIABETES ○ INSULIN
○ ORAL AGENTS
☐ LUPUS
☐ OTHER _____

NEUROLOGICAL
☐ FREQUENT HEADACHES
☐ PARALYSIS/WEAKNESS
☐ DIZZY/LIGHTHEADED
☐ CONVULSIONS/TREMORS
☐ NUMBNESS/TINGLING
☐ OTHER _____

PSYCHIATRIC
☐ TROUBLE SLEEPING
☐ CONFUSION/MEMORY LOSS
☐ DEPRESSION
☐ PANIC/ANXIETY ATTACKS
☐ SUICIDE ATTEMPT
☐ OTHER _____

MISCELLANEOUS
☐ NIGHT SWEATS
☐ FATIGUE
☐ HIV/AIDS
☐ OTHER _____

PATIENT SIGNATURE _____ DATE _____

PHYSICIAN SIGNATURE _____ DATE _____