

Associates in Internal Medicine Health Information Form

Name _____

Date _____

I am here for (check one)

Complete annual physical
 Follow up on old Problems

New problem(s)
 Other

In the last 6 months, have you had any unusual...

GENERAL/CONSTITUTIONAL

Fevers?	Y	N
Night sweats?	Y	N
Fatigue?	Y	N
Have you gained or lost >10lbs in 6 months?	Y	N
Sleepiness during day?	Y	N

EYES

Eye pain?	Y	N
Blurry vision?	Y	N
Change in your vision?	Y	N

HEAD & NECK

Ringling in the ears?	Y	N
Loss or change in your hearing?	Y	N
Ear pain?	Y	N
Runny nose?	Y	N
Sore throat?	Y	N
Hoarseness or voice changes?	Y	N
Nosebleeds?	Y	N

RESPIRATORY

Persistent cough?	Y	N
Sputum/Phlegm production?	Y	N
Shortness of breath?	Y	N
Coughing up blood?	Y	N
Has anyone told you that you are a loud snorer or that you have "stopped breathing" at night?	Y	N

CARDIAC

Unexplained chest discomfort?	Y	N
Palpitations?	Y	N
Unusual shortness of breath with activity?	Y	N
Shortness of breath when lying flat?	Y	N
Do you awaken from sleep with shortness of breath?	Y	N
Pain in your calves at rest or with exercise?	Y	N
Leg swelling?	Y	N

GASTROINTESTINAL

Abdominal pains?	Y	N
Nausea?	Y	N
Vomiting?	Y	N
Diarrhea?	Y	N
Constipation?	Y	N
Blood in your stool?	Y	N
Black tarry stool?	Y	N
Have your bowel habits changed?	Y	N
Loss of appetite?	Y	N
Does food get "stuck" when you swallow?	Y	N
Heartburn more than once/week?	Y	N

I have reviewed form with patient
 _____, MD

Date: _____

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Preventative Health

When was your last tetanus Shot? _____ Last Pneumovax or the "pneumonia shot"? _____

When was your last EYE exam _____ When was your last DENTAL exam? _____

Females: When was your last mammogram? _____ PAP _____? Last period? _____

Do you wear seatbelts? _____ Do you use helmets for biking and rollerblading? _____

Do you have working smoke detectors in your home? _____

Do you wear sunscreen in the sun (SPF of at least 15)? _____; Do you have a loaded gun in the home? _____; Do you practice safe sex? _____

Do you have a designated driver after having >2 alcoholic drinks? _____

If over 50 years of age:

**Oct.-January, Do you need a flu shot? _____; Last flu shot _____

When did you last have your stool checked for blood? _____

Flexible sigmoidoscopy or colonoscopy? _____

Have you been screened for Osteoporosis? _____

Males: Last PSA (prostate screening test)? _____

Family History

	Mother	Father	Grandparents	Sibling #1	#2	#3	Children
Age							
Alive/Deceased							
Heart attack							
High Blood Pressure							
Stroke							
Diabetes							
Breast Cancer							
Colon Cancer							
Prostate Cancer							
Osteoporosis							
Thyroid Disease							

Past Medical History

Diabetes	Y	N
High Blood Pressure	Y	N
Lung Disease or Asthma	Y	N
Heart Disease	Y	N
Cancer	Y	N
Ulcers	Y	N
Depression	Y	N
High Cholesterol	Y	N
Arthritis	Y	N

Details (including when diagnosed)

Any other chronic diseases we should know about:

Past Surgical History

Surgeries	Year	Hospital	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Date: _____