INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

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

ALLERGY REACTION

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREFERRED PHARMACY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS**

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

DRUG NAME, STRENGTH/DOSE, AND FREQUENCY

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNIZATION HISTORY**

Most recent date:

* Flu Shot Date:\_\_\_\_\_\_\_\_\_\_\_\_\_
* Pneumonia Date:\_\_\_\_\_\_\_\_\_\_\_\_\_
* Tdap (Tetanus and pertussis) Date:\_\_\_\_\_\_\_\_\_\_\_\_\_
* Tetanus Date:\_\_\_\_\_\_\_\_\_\_\_\_\_
* Zostavax (Shingles) Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

**(WOMEN ONLY) OBSETRIC 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: \_\_\_\_\_\_

* 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 Female Male

Do you use condoms Yes No

Other Birth control method used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interested in being screened for STD's Yes No

**PAST MEDICAL HISTORY**

Please check all that apply:

|  |  |  |  |
| --- | --- | --- | --- |
| Alcoholism |  | Depression |  |
| Anxiety Disorder |  | Arthritis |  |
| Asthma |  | Bleeding Disorder |  |
| Blood Clots/DVT |  | Cancer |  |
| Coronary Artery Disease |  | Heart Cath or Stents |  |
| Diabetes |  | Claustrophobia |  |
| Dialysis |  | Diverticulitis |  |
| Fibromyalgia |  | Gout |  |
| Has Pacemaker |  | Heart Attack |  |
| Heart Murmur |  | Hiatal Hernia |  |
| HIV or AIDS |  | High Cholesterol |  |
| High Blood Pressure |  | Kidney Disease |  |
| Kidney Stones |  | Leg/Foot Ulcers |  |
| Liver Disease |  | Osteoporosis |  |
| Pulmonary Embolism |  | Stomach Ulcers or Reflux |  |
| Stroke |  | Thyroid Disorder |  |
| Sleep Disorder |  | COPD |  |
| Other |  |  |  |

**PAST SURGICAL HISTORY**

SURGERY DATE (MO/YR)

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**FAMILY HEALTH HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| RELATION | ALIVE? | AGE | HEALTH HISTORY |
| Maternal Grandmother |  |  |  |
| Maternal Grandfather |  |  |  |
| Paternal Grandmother |  |  |  |
| Paternal Grandfather |  |  |  |
| Father |  |  |  |
| Mother |  |  |  |
| Brother/Sister (specify) |  |  |  |
| Brother/Sister (specify) |  |  |  |
| Other (specify) |  |  |  |

**SOCIAL HISTORY**

**EDUCATION**

|  |  |
| --- | --- |
| Some high school | High school graduate |
| GED | 2 year college |
| 4 year college | Post graduate |

**MARITAL STATUS**

|  |  |
| --- | --- |
| Married | Single |
| Divorced | Separated |
| Widowed | Domestic Partner |

**EXERCISE LEVEL**

|  |  |
| --- | --- |
| None (No exercise) | Occasional Exercise |
| Moderate Exercise | High Level Exercise |

**ALCOHOL**

Do you drink alcohol? Yes No

If so, how often? \_\_\_\_ Occasionally

\_\_\_\_ < 3 times a week

\_\_\_\_ > 3 times a week

How many drinks per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOBACCO**

Do you use tobacco? Yes No

|  |  |
| --- | --- |
| Cigarettes | \_\_\_\_\_ pks/day |
| Chew | \_\_\_\_\_ /day |
| Cigars | \_\_\_\_\_ /day |

If not currently, did you ever use tobacco? Yes No

# of years smoked \_\_\_\_\_\_\_\_ Year quit \_\_\_\_\_\_\_\_\_\_\_\_

**DRUGS**

Do you currently use recreational or street drugs? Yes No

If yes, list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

Please check all that apply:

|  |  |  |  |
| --- | --- | --- | --- |
| Allergic/Immunologic |  | Frequent Sneezing |  |
| Itching |  | Runny Nose |  |
| Hives |  | Sinus Pressure |  |
| Cardiovascular |  | Chest Pain on Exertion |  |
| Arm Pain on Exertion |  | Known Heart Murmur |  |
| Chest Heaviness/Pressure on Exertion |  | Light-headed on Standing |  |
| Irregular Heart Beats (Palpitations) |  | Swelling (edema) |  |
| Shortness of Breath When Walking |  | Fatigue |  |
| Shortness of Breath When Lying Down |  | Fever |  |
| Exercise Intolerance |  | Weight Loss (\_\_\_\_lbs) |  |
| Weight Gain (\_\_\_\_lbs) |  | Dry Eyes |  |
| Eye Irritation |  | Vision Change |  |
| Date of Last Eye Exam: |  | Bleeding Gums |  |
| Hearing Difficulty |  | Dizziness |  |
| Ear Pain |  | Dry Mouth |  |
| Frequent Ear Infections |  | Frequent Nosebleeds |  |
| Hoarseness |  | Mouth Breathing |  |
| Mouth Ulcers |  | Nose/Sinus Problems |  |
| Ringing in Ears |  | Fatigue |  |
| Increased Thirst/Hunger/Urination |  | Abdominal Pain |  |
| Black or Tarry Stool |  | Blood in Stool |  |
| Change in Appetite |  | Frequent Indigestion |  |
| Hemorrhoids |  | Trouble Swallowing |  |
| Vomiting |  | Vomiting Blood |  |
| Blood in Urine |  | Difficulty Urinating |  |
| Incomplete Emptying |  | Increased Urinary Frequency |  |
| Urinary Loss of Control |  | Easy Bruising/Bleeding |  |
| Swollen Glands |  | Changes in Moles |  |
| Dry Skin |  | Eczema |  |
| New Lesions/Growths |  | Itching |  |
| Jaundice (Yellow Skin/Eyes) |  | Rash |  |
| Back Pain |  | Joint Pain |  |
| Muscle Aches |  | Muscle Weakness |  |
| Dizziness |  | Fainting |  |
| Headaches |  | Memory Loss |  |
| Migraines |  | Numbness |  |
| Restless Legs |  | Seizures |  |
| Weakness |  | Anxiety/Stress |  |
| Alcohol Overuse |  | Depression |  |
| Sleep Problems |  | Cough |  |
| Coughing Up Blood |  | Shortness of Breath |  |
| Sleep Apnea |  | Snoring |  |
| Wheezing |  |  |  |

Please add any other information about your health that you would like your provider to know here:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent, Guardian, or Caregiver Signature Date