General Internal Medicine Group
Medical History Form

Name: ____ DOB: ____________________

ALLERGIES: □ None
□ penicillin □ sulfa □ codeine □ aspirin □ antibiotic (list below) □ other (list below)
_______________________________ ____________________________ ___________________________

IMMUNIZATIONS:

VACCINE NAME	*DATE*	*VACCINE NAME*	*DATE*
Tetanus/diphtheria Vaccine (TD)		Meningitis Vaccine	
Tetanus / Diphtheria / Pertussis vaccine (Tdap)		Hepatitis B Vaccine	
Flu Vaccine		Gardasil / HPV Vaccine	
Pneumonia Vaccine		Zostavax / Shingles Vaccine	

SELF / FAMILY HISTORY: Please put a checkmark in all applicable boxes
* Were you adopted? □ Yes □ No

ILLNESS	SELF	FATHER	MOTHER	SIBLING : SISTER BROTHER	CHILD (SON / DTR)	MATERNAL GRAND MOTHER	MATERNAL GRAND FATHER	PATERNAL GRAND MOTHER	PATERNAL GRAND FATHER	OTHER: (PLEASE SPECIFY)
Alcohol/drug addiction										
Anemia										
Asthma										
Bleeding/clotting Disorder										
Breast Cancer										
Bowel Problem (specify)										
Cancer (other-specify)										
Colon Cancer										
Colon polyps										
Coronary Artery Disease										
Depression/Anxiety										
Diabetes										
Glaucoma										
Heart Attack / Bypass Angioplasty										
High Cholesterol										
High Blood Pressure										
Kidney Disease										
Liver Disease										
Lung Caner										
Ovarian Cancer										
Prostate Cancer										
Skin Cancer										
Stroke										
Schizophrenia										
Seizures/Epilepsy										
Suicide										
Thyroid disease										

SOCIAL HISTORY:

Marital Status: (check one) □ Single □ Married □ Divorced □ Separated □ Widowed □ Partner

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Occupation: ___________________________ Current Work Status: FT, PT, Disabled, Retired, Self employed, unemployed

Country **of birth**: ___________________ Year **arrived in U.S.**: ________

Nutrition: □ Well-balanced diet □ Poorly balanced diet □ Vegetarian □ Low fat □ Weight reduction (specify) □ Other ________

Exercise regularly? □Yes □No Days per week? ______ Minutes/day? _______

□Bicycling □Elliptical □Golf □Pilates □Racquet sports □Running □Swimming □Team sport □Treadmill □Walking □Weights

□Yoga other: ____

Tobacco use? □ Never smoker □ Former smoker: Quit, year quit? _______ --- Smoked # Packs Per Day ____ for ____ years?

□ Current some day smoker : How often?______________ □ Current daily smoker: # Packs Per Day ____ for ____ years?

Alcohol Use? □ Yes (servings= Beer 12oz, Wine 6oz, Liquor 1.5oz) Number of drinks ____ per: □ day □ week □ month □ year ?
□ Never drinker □ Former drinker ---- □ Quit, year quit? _______ {□ Would like to quit }

Illicit Drug use? Current use?: □ Yes □ No Past use?: □ Yes □ No □ Marijuana □ Cocaine □ Heroine □ Meth □ Ecstasy

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Caffeine use?: □ None □ Coffee □ Tea □ Carbonated beverages Average servings of caffeinated beverages / day : ________

Seat belt use? □ Always □ Almost Always □ Occasionally □ Never

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Guns in the home? □ None / □ Yes: □ Secured with safety locks □ Secured in cabinet □ Not secured

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Smoke detector in home? □ Yes □ No

Fall Risk Assessment, if 65 year old or older: □ Stable walking gait □ unstable walking gait (unsteady walking)
□ Able to rise from a chair without assistance □ Unable to rise from a chair without assistance
□ No falls in the past year □ Less than 2 falls in the last year □ More than 2 falls in the last year

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Do you have a Living Will? □ Yes □ No ** A living will is a legal document that a person uses to make known his or her wishes regarding life prolonging medical treatments*

Do you have a D.N.R. directive? □ Yes □ No * *DNR stands for "Do Not Resuscitate" A person who does not wish to have cardiopulmonary resuscitation (CPR) performed may make this wish know through a doctor's order called a DNR order.*

Medical Power of Attorney? □ Yes □ No If yes, Name: ________________ Relationship: _________ Phone #________

MEDICATIONS (Prescriptions, Over The Counter, Vitamins, Supplements, Other) :

MEDICINE NAME	*DOSE*	*DIRECTIONS, HOW YOU TAKE THE MEDICINE*

WOMEN:

OB/GYN HISTORY: Age of first menses:_____ Date of last period:________ Do you suffer from PMS □ Yes □ No

Pregnancies: Total___ Full Term___ Vaginal deliveries___ C-sections___ Terminations___ Miscarriages___ Tubal___ Premature__

PAST SURGERIES:

TYPE OF SURGERY	*DATE*	*TYPE OF SURGERY*	*DATE*

HEALTH MAINTENANCE:

Date of last Eye Exam? __________________________ Date of last Bone Density? _________________
Date of last Colonoscopy? ___________ □ Normal □ Abnormal ---- Any **past** history of Abnormal results?___________________
Diabetics: Last foot exam? __________________________
Date of last Mammogram? ___________□ Normal □ Abnormal ---- Any **past** history of Abnormal results?___________________
Date of last PAP smear? _____________□ Normal □ Abnormal ---- Any **past** history of Abnormal results?___________________
Date of last Prostate exam?___________ □ Normal □ Abnormal ---- Any **past** history of Abnormal results?___________________
Date of last Physical Exam? _______________________ Date of last HIV screening? ________________

Your Signature: ____ Date: ______________________