INTERNAL MEDICINE CENTER, LLC
Established 1946
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REPORT OF MEDICAL HISTORY

Today's Date:_____ Chart #:_____
Name:_____ Doctor:_____
1) What is the primary reason for your visit to the doctor today?:_____
2) Patient Social History:
Marital Status: Single_____ Married_____ Separated_____ Divorced_____ Widowed_____
Use of Alcohol: Never_____ Rarely_____ Moderate_____ Daily_____
Use of Tobacco: Never_____ Previously, but quit_____ Current packs/day_____
Use of Drugs: Never_____ Type/Frequency_____
3) Family Medical History:

	Age	Disease	If Deceased, Cause of Death
Father	____	_____	_____
Mother	____	_____	_____
Sibling	____	_____	_____
Sibling	____	_____	_____

4) Do you exercise on a regular basis? Yes_____ No_____
5) *Females*: Last Pap Date:_____ ____ *Males*: Last Prostate Evaluation Date:_____
Last Mammogram Date:_____ ____ By Dr._____
By Dr._____

PERSONAL HEALTH HISTORY

Check yes or no for each of the following. Have you ever had any history of or been treated for any of the following?

YES	NO		YES	NO	
		Heart disease			Prostate trouble
		Heart failure			Kidney stones
		High blood pressure			Difficulty urinating
		Chest pain			Headaches
		Heart palpitation			Stroke
		Shortness of breath at night or with walking			Seizure
		Chronic cough, wheezing, or asthma			Loss of consciousness
		Pneumonia or tuberculosis			Dizziness
		Coughing up blood			Arthritis or joint disease
		Heartburn or indigestion			Disorder of breasts
		Hiatus hernia, or ulcer disease			Disorder of ovaries or uterus
		Abdominal pain			High blood sugar or diabetes
		Diarrhea or colitis			High cholesterol
		Constipation			Disorder of thyroid gland
		Gallbladder disease			Fever, night sweats
		Difficulty swallowing or food lodged in throat			Cancer
		Hepatitis or liver disease			Anemia
		Vomiting blood			Weight loss
		Blood in stool			Difficulty sleeping
		Kidney infection			Depression, anxiety, stress, fatigue or loss of energy (circle all that apply)

(over)

Do you take any regular medications? *Yes*____ *No*____ If yes, please list:

Are you allergic to any medications? *Yes*____ *No*____ If yes, please list:

Have you ever been hospitalized? *Yes*____ *No*____
If so, please list reason for hospitalization with approximate dates.

Do you have any other symptoms or medical history that your doctor should be aware of? *Yes*__ *No*__