

GAINESVILLE INTERNAL MEDICINE PHYSICIANS

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MEDICAL HISTORY FORM

DATE: _____

NAME: _____ Birth Date _____ Age _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

OCCUPATION: _____ PHONE NUMBER: HOME _____ WORK _____

REFERRING PHYSICIAN: _____

INSURANCE &/OR MEDICARE #: _____ SOCIAL SECURITY #: _____

MEDICAID #: _____

WHO IS FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL CARE? _____

PROBLEMS: (State why you want to see a doctor and if for more than one reason. List in order of importance to you.) You may use last page to describe in detail if you wish.

1. _____
2. _____
3. _____
4. _____

LIST OTHER PHYSICIANS SEEN IN LAST TWO YEARS AND WHY. _____

PAST MEDICAL HISTORY:

1. Illnesses (requiring hospitalization, list problem and year, do not list operations here)

- | | |
|-----------|-----------|
| (a) _____ | (d) _____ |
| (b) _____ | (e) _____ |
| (c) _____ | (f) _____ |

2. Accidents (List broken bones, unconscious episodes, and all others):

- | | |
|-----------|-----------|
| (a) _____ | (d) _____ |
| (b) _____ | (e) _____ |
| (c) _____ | (f) _____ |

3. Operations (list all and give year):

- | | |
|-----------|-----------|
| (a) _____ | (d) _____ |
| (b) _____ | (e) _____ |
| (c) _____ | (f) _____ |

4. Allergies: (Have you had reactions to any of the following medications [yes or no] and describe the reaction, for example, "Rash, asthma, hayfever")

- | | | |
|-----------------------|-------------------|------------------------|
| (a) Penicillin _____ | (c) Aspirin _____ | (e) Demerol _____ |
| (b) Sulfa _____ | (d) Codeine _____ | (f) Barbiturates _____ |
| (g) Anesthetics _____ | | |
| (h) Other _____ | | |

5. Pregnancies _____ Miscarriages _____ Weight of Largest Child at birth _____

6. Medications (list all you are now taking or have taken [in the past month] indicate how often you take them): BRING ALL MEDICATIONS WITH YOU.

- | | | |
|-----------|-----------|------------------------------|
| (a) _____ | (e) _____ | (i) How much aspirin _____ |
| (b) _____ | (f) _____ | (j) Laxatives _____ |
| (c) _____ | (g) _____ | (k) Oral contraceptive _____ |
| (d) _____ | (h) _____ | (l) Sleeping pills _____ |

REVIEW OF SYSTEMS: Review the list below and **circle** any number that describes a problem you are currently having and **underline** those problems you have frequently had in the past.

- | | |
|--|--|
| 1. Headaches | 41. Black, Loose Bowel Movements |
| 2. Seizures or Fits | 42. Stomach Pain |
| 3. Numbness or Tingling in Hands, Feet, Arms, Legs | 43. Jaundice (Yellow Skin) |
| 4. Weakness in Hands, Feet, Arms, Legs | 44. Stomach Ulcers |
| 5. Difficulty Maintaining Balance | 45. Hemorrhoids |
| 6. Dizziness | 46. Weight Loss |
| 7. Fainting or Black-out Spells | 47. Weight Gain in Past Year |
| 8. Strokes | 48. Loss of Appetite |
| 9. Ringing in Ears | 49. Frequent Urination or Passing Water |
| 10. Difficulty with Hearing | 50. Urination at Night |
| 11. Difficulty with Vision | 51. Pain on Urination |
| 12. Double Vision | 52. Pus or Milky Color in Urine (Water) |
| 13. Difficulty Smelling Things | 53. Blood in Urine |
| 14. Excessive Sneezing | 54. Pass a Stone in Urine |
| 15. Trouble Breathing Through Nose | 55. Reduction in Force or size of Urine |
| 16. Nose Bleeds | 56. Difficulty Starting Urine Stream |
| 17. Change in Voice | 57. Leakage of Urine |
| 18. Shortness of Breath at Night | 58. Difficulty with Erection |
| 19. Shortness of Breath while Walking | 59. Difficulty with Ejaculation |
| 20. Swelling of Ankles or Feet | 60. Discharge from Penis |
| 21. Palpitations | 61. Onset of Menstruation (Age) _____ |
| 22. Chest Pain or Tightness in Chest | 62. Duration of Menstruation in Days _____ |
| 23. Heart Attacks | 63. Length of Interval Between Periods _____ |
| 24. High Cholesterol | 64. Bleeding Between Periods |
| 25. Swelling of Legs | 65. Painful Periods |
| 26. Cough | 66. Irregular Periods |
| 27. Cough Up Blood | 67. Last Menstrual Period _____ |
| 28. Wheezing during Breathing | 68. Last Pelvic _____ |
| 29. Sugar Diabetes | 69. Last Mammogram _____ |
| 30. High Blood Pressure | 70. Vaginal Discharge |
| 31. Night Sweats | 71. Back Pain-High |
| 32. Continuous Fever for Greater than 5 Days | 72. Back Pain-Low |
| 33. Nausea, Chronic | 73. Change in Glove, Shoe or Hat Size |
| 34. Trouble with Swallowing | 74. Muscle Cramps in Arms, Legs, Hands, Feet |
| 35. Vomiting | 75. Pain in Legs while Walking |
| 36. Diarrhea, Chronic | 76. Joint Swelling |
| 37. Constipation, Chronic | 77. Joint Pain |
| 38. Last Colonoscopy _____ | 78. Pain in Hands or Feet in Cold Weather |
| 39. Vomit Blood | 79. Skin Rash |
| 40. Have Blood with Bowel Movements | 80. Dry Skin |

81. Increase in Oiliness of Skin
82. Loss of Hair
83. Increase in Hair Growth
84. Hives
85. Excessive Sweating
86. Prefer Hot Weather
87. Prefer Cold Weather
88. Itching of Skin
89. Skin Pallor (Paleness)
90. Breast Discharge
91. Lumps in Breast
92. Painful Breasts
93. Excessive Blistering after Sun Exposure
94. Change in Facial Appearance
95. Easy Bruising

96. Excessive Bleeding after Cutting Skin
97. Crying Spells
98. Insomnia
99. Mood Swings
100. Nervousness
101. Difficulty with Memory
102. Problem with Thinking Clearly
103. Chronic Fatigue or Weakness
104. Depression and Anxiety
105. Weight Change
106. How many oz. of Alcohol Consumed a Week _____
107. How many Packs of Cigarettes do you smoke Each Day? _____

Weight Age 20 _____ Weight 1 year ago _____ Weight now _____

FAMILY HISTORY:		Age	State of Health	Cause of Death
Father		_____	_____	_____
Mother		_____	_____	_____
Brothers		_____	_____	_____
		_____	_____	_____
Sisters		_____	_____	_____
		_____	_____	_____
Spouse		_____	_____	_____
Children	M F	_____	_____	_____
(Circle one)	M F	_____	_____	_____
	M F	_____	_____	_____
	M F	_____	_____	_____

WHO IN YOUR FAMILY HAD:	Father	Mother	Sister(s)	Brother(s)	Other
1. Goiter					
2. Cancer					
3. Tuberculosis					
4. Allergies or asthma					
5. Strokes					
6. Nervous breakdown					
7. Suicide					
8. Convulsions/epilepsy					
9. Headaches					
10. Diabetes					
11. Arthritis					
12. Heart Attack					
13. High blood pressure					
14. Gout					
15. Kidney Stone					
16. Bleeding problem					
17. Ulcers					
18. Stroke or Heart Attack Prior to Age 60					

