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

PERSONAL HISTORY:

1. Occupation: Yours _____ Spouses' _____

2. Place of Employment: _____

3. Education: (Circle level completed) High School 9 10 11 12 College 1 2 3 4 Masters Ph.D. Others

4. Marital Status: (circle) Single Married Widowed Separated Divorced

   Spouse's Name: _____

5. Religious preference: _____

6. Hobbies: (list) _____

7. Smoking History: Packs each day? _____ For how long in years? _____

   When did you quit? _____

8. Drinking History: Ounces each day? _____ For how long in years? _____

9. List the individuals that live in your home: _____

   _____

10. Whom should we contact in the event you develop a medical emergency (Give name, address, phone number and relation to you)

    _____

    _____

11. How much exercise do you get (walking, jogging, bicycling, swimming, golf, tennis, other--circle please):

    Min each day? _____ Hours per week? _____

    Moderate occupational and recreational exercise? _____

    Sedentary work and light exercise only? _____

12. What additional information should the doctor have about you? _____

    _____

_____

Patient's signature