Internal Medicine Associates of Raleigh, P.A.

Patient's Personal History

Patient No. ____________________

Date ____________________

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name	First	Middle	Birth Date		Birth Place
			Sex	**Marital Status**	**Religion**
			M / F		

Family History		If Living	If Deceased	Medical History
	Sex	Age	Age at Death	
Father				
Mother				
Brothers/Sisters* *(Please list names and circle sex)*				
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
Husband/Wife				
Sons/Daughters* *(Please list names and circle sex)*				
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			

* Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter.

Do you know of any relative who has or has had: (Circle and give relationship)

Stroke ______ Heart Disease ______ Glaucoma ______ Cancer ____ List type ______

Thyroid Problem ______ Depression/ Mental Illness ______ High Blood Pressure ______ Migraine ______

Asthma ______ Kidney Disease ______ Hay Fever ______ Goiter ______

Diabetes ______ Arthritis ______ Bleeding Tendency ______ Colitis ______

Osteoporosis ______ High Cholesterol ______ Alcoholism ______ Other ______

Allergies (Medicine, Food, Latex, etc.)/Reactions ______

______

______

______

Current Medications (include medications taken for sleep and as a laxative)

MEDICATION	DOSE	FREQUENCY TAKEN	MEDICATION	DOSE	FREQUENCY TAKEN

List Surgeries/Hospitalizations with Dates: ______

______

______

______

______

______

List Previous and Current Conditions Being Treated for(e.g. high blood pressure, diabetes):

______

______

______

______

______

Have you ever had a blood transfusion? ☐ No ☐ Yes When:____________________

Use of Tobacco: ☐ No Stopped When:____________________

☐ Cigarettes ____Packs/day for # years ____________ ☐ Pipe ☐ Cigar ☐ Chewing Tobacco ☐ Snuff

Use of Alcohol: Amount ________ Type________

Dairy Portions per Day: (eg. 8oz. glass of milk, 1oz. cheese, a yogurt) ____________________

Are you sexually active? ☐ Now ☐ Ever With ☐ Men ☐ Women

Do you wear a seat belt? ☐ No ☐ Yes

Are you or have you been a victim of domestic violence? ☐ No ☐ Yes Do you want to talk about it? ☐ No ☐ Yes

Do you exercise? ☐ No ☐ Yes Frequency ______ Type ____________________

Do you live alone? ☐ Yes ☐ No With whom? ____________________

Has there been a change in your marital status in the last year? ☐ No ☐ Yes

Has there been a death in your family in the last year? ☐ No ☐ Yes

Do you have any special requests due to your religious practices/culture/values? ☐ No ☐ Yes ____________

Education: Last grade completed: ____________________

Present Occupation: ____________________

If retired, what was your previous employment? ____________________

Do you have an advanced directive? ☐ Living Will ☐ Health Care Power of Attorney ☐ No

Systems Review

A. GENERAL	YES	NO
1. Do you usually feel tired?	☐	☐
2. Night sweats/ fevers	☐	☐
B. SKIN *Have you noticed:*		
1. Skin rashes or itching	☐	☐
2. Growths on the skin	☐	☐
3. Sores that do not heal	☐	☐
4. Changes in the color or size of moles	☐	☐
C. EYES *Have you noticed:*		
1. Blurred vision	☐	☐
2. Double vision	☐	☐
3. Draining or itching eyes	☐	☐
4. Pain in your eyes	☐	☐
D. ENT *Have you had:*		
1. Difficulty hearing	☐	☐
2. Nasal stuffiness or drainage	☐	☐
3. Frequent or severe nosebleeds	☐	☐
4. Mouth sores that do not heal	☐	☐
E. RESPIRATORY *Have you had:*		
1. Difficulty breathing	☐	☐
2. To sleep on more than one pillow to breathe	☐	☐
3. Waking up short of breath	☐	☐
4. A constant cough	☐	☐
5. Coughing up blood	☐	☐
6. Wheezing in your chest	☐	☐

F. CARDIOVASCULAR *Have you had:*	YES	NO
1. Pain/pressure in your chest, jaw, arm with exercise	☐	☐
2. Palpitations of your heart	☐	☐
3. Swelling in your ankles	☐	☐
4. Cramps/pain in legs w/ walking	☐	☐
5. Changes in color of fingers or toes	☐	☐
6. A previous heart murmur	☐	☐
G. MUSCULOSKELETAL *Have you had:*		
1. Pain in joints	☐	☐
2. Swelling in joints	☐	☐
3. Morning stiffness in joints	☐	☐
4. Pain in joints in cold weather	☐	☐
5. Low back pain limiting activities	☐	☐
H. GASTROINTESTINAL *Have you had:*		
1. Any change in appetite	☐	☐
2. Any weight changes recently	☐	☐
3. Difficulty swallowing	☐	☐
4. Abdominal or stomach pains	☐	☐
5. Food intolerances	☐	☐
6. Vomiting of blood	☐	☐
7. Black or tarry stools	☐	☐
8. Blood in stools	☐	☐
9. Persistent/severe diarrhea in last 3 months	☐	☐
10. Constipation on regular basis	☐	☐
11. Regular use of laxatives	☐	☐
12. Frequent nausea/vomiting	☐	☐
13. Persistent heartburn or reflux	☐	☐

Systems Review Continued

Completed by:

I. URINARY *Have you had:*

	YES	NO
1. Difficulty with urination	☐	☐
2. Burning or pain with urination	☐	☐
3. Hesitation with urination	☐	☐
4. Getting up at night to urinate	☐	☐
5. Blood in urine	☐	☐
6. Problems with sexual function	☐	☐
7. (Men) prostate gland trouble	☐	☐
8. Loss of control of bladder	☐	☐

J. NERVOUS SYSTEM *Have you had:*

	YES	NO
1. Frequent or severe headaches	☐	☐
2. Dizziness or light-headedness	☐	☐
3. Episodes of fainting	☐	☐
4. Difficulty remembering recent events	☐	☐
5. Episodes of crying or urge to cry	☐	☐
6. Difficulty sleeping	☐	☐
7. Feelings of agitation or loss of control	☐	☐
8. Tingling or numbness arms/legs	☐	☐
9. Difficulty with balance or coordination	☐	☐
10. Spells of weakness of arm/leg	☐	☐
11. Feelings of guilt or hopelessness	☐	☐
12. Trouble with concentration or motivation	☐	☐
13. Significant anxiety, feeling sad or depressed	☐	☐

K. GYN (WOMEN ONLY) *Have you had:*

	YES	NO
1. Regular monthly periods	☐	☐
2. Date last period: ____________		
3. Spotting/bleeding between your periods	☐	☐
4. Heavy bleeding with your period	☐	☐
5. Pain or cramping with your periods	☐	☐
6. Bloating/irritability before your period	☐	☐
7. Use birth control (Form:)		
8. Hot flashes	☐	☐
9. Have you passed menopause	☐	☐
10. Vaginal discharge	☐	☐
11. Monthly self breast exam	☐	☐
12. Hormone therapy	☐	☐

# of pregnancies__________ # live children__________

# of miscarriages__________ # of stillborns__________

# of C-sections__________

Complications with pregnancy(s):

Comments on sections in which responded yes: ____________

Completed by: ____________

Relationship to Patient: ____________