Internal Medicine Associates of Raleigh, P.A.

Date: _____ Physician: _____

HEALTH HISTORY ASSESSMENT UPDATE

Name: _____ Birth Date: _____

Address: _____

Allergies/Reactions: _____

_____

_____

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

MEDICATION	DOSE	FREQUENCY TAKEN	MEDICATION	DOSE	FREQUENCY TAKEN

New health problems: _____

_____

_____

_____

Surgeries/Hospitalizations Since Last Visit: _____

_____

_____

_____

Other changes in your life of which you wish your physician to be aware: _____

_____

_____

_____

Changes in family medical history: _____

_____

_____

_____

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:*		
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	☐	☐
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	☐	☐

Comments on sections in which responded yes:

_____

_____

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Completed by: _____

H. GASTROINTESTINAL *Have you had:*	YES	NO
1. Any change in appetite	☐	☐
2. Any weight changes recently	☐	☐
3. Difficulty swallowing	☐	☐
4. Abdominal or stomach pains	☐	☐
5. Food intolerances	☐	☐
6. Vomitting 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/vomitting	☐	☐
13. Persistent heartburn or reflux	☐	☐
I. URINARY *Have you had:*		
1. Difficulty with urination	☐	☐
2. Burning or pain with urination	☐	☐
3. Hestitation with urination	☐	☐
4. Getting up at night to urinate	☐	☐
5. Blood in urine	☐	☐
6. Are you sexually active?	☐	☐
7. Problems with sexual function	☐	☐
8. (Men) prostate gland trouble	☐	☐
9. Loss of control of bladder	☐	☐
J. NERVOUS SYSTEM *Have you had:*		
1. Frequent or severe headaches	☐	☐
2. Dizziness or light headaches	☐	☐
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. Trouble sleeping	☐	☐
10. Difficulty with balance or coordination	☐	☐
11. Spells of weakness of arm/leg	☐	☐
12. Feelings of guilt or hopelessness	☐	☐
13. Trouble with concentration or motivation	☐	☐
14. Significant anxiety, feeling sad or depressed	☐	☐
K. GYN (WOMEN ONLY) *Have you had:*		
1. Regular monthly periods	☐	☐
2. Spotting/bleeding between your periods	☐	☐
3. Heavy bleeding with your period	☐	☐
4. Pain or cramping with your periods	☐	☐
5. Bloating/irritability before your period	☐	☐
6. Hot flashes	☐	☐
7. Have you passed menopause	☐	☐
8. Vaginal discharge	☐	☐
9. Monthly self breast exam	☐	☐
10. hormone therapy	☐	☐
Date of last period:	☐	☐

# of pregnancies _____ # live children _____

# of miscarriages_____ # of stillborns _____

# of C-sections

Complications with pregnancy (s)

_____

_____

_____

Relationship to Patient: _____