Internal Medicine Associates of John's Creek, Inc.

MEDICAL HISTORY FORM

Date: _____

Patient Name: _____
(First) (Middle) (Last)

Street Address: _____
(Mailing Address)

_____ _____ _____
(City) (State) (Zip)

SEX _____
(M or F)

Single ___ Married___ Divorced___ Widowed___ Separated___

Instructions

Please fill in entire circle as accurately and completely as possible with a dark pen. Example : ● Correct - ○please do not use a × or ✓ in the○

Please answer every question with an answer

This information is for your current medical status

Social History

Alcohol:	O	Yes	O	No
Smoking:	O	Yes	O	No
Sexually active:	O	Yes	O	No
Recreational drug use:	O	Yes	O	No

Exercise:	O	Yes	O	No
Caffeine:	O	Yes	O	No

Family History

Mother	O Cancer	O High BP	O Heart Disease
	O Strokes	O Mental Disease	
Mother	O Alcohol or Drug Addiction		O Glaucoma
	O Bleeding Disease		O Other (Diabetes)
Siblings	O Cancer	O High BP	O Heart Disease
	O Strokes	O Mental Disease	
Siblings	O Alcohol or Drug Addiction		O Glaucoma
	O Bleeding Disease		O Other (Diabetes)
Children	O Cancer	O High BP	O Heart Disease
	O Strokes	O Mental Disease	
Children	O Alcohol or Drug Addiction		O Glaucoma
	O Bleeding Disease		O Other (Diabetes)
Father	O Cancer	O High BP	O Heart Disease
	O Strokes	O Mental Disease	
Father	O Alcohol or Drug Addiction		O Glaucoma
	O Bleeding Disease		O Other (Diabetes)

CONSTITUTIONAL

weight gain	O	Yes	O	No
loss of appetite	O	Yes	O	No
fever	O	Yes	O	No
weakness	O	Yes	O	No
breast feeding	O	Yes	O	No
weight loss	O	Yes	O	No
fatigue	O	Yes	O	No
appetite reduced	O	Yes	O	No

HEENT (ENT)

cold	O	Yes	O	No
cough	O	Yes	O	No
epistaxis(nose bleed)	O	Yes	O	No
hearing loss	O	Yes	O	No
change in voice	O	Yes	O	No
sore throat	O	Yes	O	No
ringing in ears	O	Yes	O	No
sinus pain	O	Yes	O	No
ear fullness	O	Yes	O	No
itchy eyes	O	Yes	O	No
runny nose	O	Yes	O	No
scratchy throat	O	Yes	O	No
sinus congestion	O	Yes	O	No

RESPIRATORY

shortness of breath	O	Yes	O	No
chest pain	O	Yes	O	No
chest congestion	O	Yes	O	No
cough	O	Yes	O	No

CARDIOLOGY

dizziness	O	Yes	O	No
chest pain	O	Yes	O	No
palpitations	O	Yes	O	No
leg edema	O	Yes	O	No
shortness of breath	O	Yes	O	No
varicose veins	O	Yes	O	No

GASTROENTEROLOGY

blood in stool	O	Yes	O	No
diarrhea	O	Yes	O	No
vomiting	O	Yes	O	No
constipation	O	Yes	O	No
nausea	O	Yes	O	No
trouble swallowing	O	Yes	O	No
abdominal pain	O	Yes	O	No
heartburn	O	Yes	O	No
hemorrhoids	O	Yes	O	No

FEMALE REPRODUCTIVE

hot flashes	O	Yes	O	No
abnormal vaginal discharge	O	Yes	O	No
heavy periods	O	Yes	O	No
painful intercourse	O	Yes	O	No
sexually active	O	Yes	O	No
painful periods	O	Yes	O	No
infertility	O	Yes	O	No
frequent yeast infections	O	Yes	O	No
pelvic pain	O	Yes	O	No
breast pain	O	Yes	O	No
nipple discharge	O	Yes	O	No
birth control	O	Yes	O	No
menopause	O	Yes	O	No

MALE REPRODUCTIVE

difficulty with erection	O	Yes	O	No
diminished sexual drive	O	Yes	O	No
penile discharge	O	Yes	O	No
contraception	O	Yes	O	No

MUSCULOSKELETAL

joint stiffness	O	Yes	O	No
leg cramps	O	Yes	O	No

joint pain	O	Yes	O	No
joint swelling	O	Yes	O	No
sciatica	O	Yes	O	No
osteoporosis treatment	O	Yes	O	No
fracture	O	Yes	O	No
carpal tunnel	O	Yes	O	No

HEMATOLOGY/LYMPH

swollen glands	O	Yes	O	No
fatigue	O	Yes	O	No
loss of appetite	O	Yes	O	No
varicose veins	O	Yes	O	No
easy bruising	O	Yes	O	No

DERMATOLOGY

rash	O	Yes	O	No
mole	O	Yes	O	No
lumps	O	Yes	O	No
dry or sensitive skin	O	Yes	O	No
hives	O	Yes	O	No
acne	O	Yes	O	No
skin cancer	O	Yes	O	No

NEUROLOGY

headache	O	Yes	O	No
tingling numbness	O	Yes	O	No
seizures	O	Yes	O	No
insomnia	O	Yes	O	No
memory loss	O	Yes	O	No
dizziness	O	Yes	O	No
gait abnormality	O	Yes	O	No

PSYCHOLOGY

depression	O	Yes	O	No
high stress level	O	Yes	O	No
sleep disturbances	O	Yes	O	No
suicidal ideation	O	Yes	O	No
eating disorder	O	Yes	O	No
mental or physical abuse	O	Yes	O	No
anxiety	O	Yes	O	No

OPTHALMOLOGY

diminished vision	O	Yes	O	No
eye irritation	O	Yes	O	No
drainage from eyes	O	Yes	O	No
blurring of vision	O	Yes	O	No

seasonal eye symptoms	O	Yes	O	No
loss of vision	O	Yes	O	No

UROLOGY

difficulty urinating	O	Yes	O	No
blood in urine	O	Yes	O	No
frequent urination	O	Yes	O	No
urinary incontinence(leakage)	O	Yes	O	No
recurrent UTI	O	Yes	O	No
nighttime urination	O	Yes	O	No
impotence	O	Yes	O	No

ENDOCRINOLOGY

fatigue	O	Yes	O	No
thirst	O	Yes	O	No
excessive urination	O	Yes	O	No
weight loss	O	Yes	O	No
sleep disturbance	O	Yes	O	No
cold intolerance	O	Yes	O	No
heat intolerance	O	Yes	O	No
diabetes	O	Yes	O	No

Allergies to any Medications, X-Ray Dyes, or other Substances

_____ _____
(yes) (no)

If yes, please list names of medicines and type of reactions)

_____

_____

_____

_____

_____

Current Medications
(Please list any and all medications to include prescription and over the counter, vitamins and herbs, etc.)

Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please List and Supply Dates of:

Operations

1._____
(Procedure) **(Date)**
2._____
(Procedure) **(Date)**
3._____
(Procedure) **(Date)**
4._____
(Procedure) **(Date)**
5._____
(Procedure) **(Date)**

Hospitalization other than surgery

1._____

2._____

Immunization History

Hepatitis B **yes____** **no____** **when?_____**
Pneumovax **yes____** **no____** **when?_____**
Flu **yes____** **no____** **when?_____**
Tetanus **yes____** **no____** **when?_____**
Other_____ **when?_____**
Other_____ **when?_____**
Other_____ **when?_____**

When was your last?

1. **Pap Smear?** _____
2. **Mammogram?** _____
3. **Breast Check?** _____
4. **Cholesterol Check?** _____
5. **Stool Check for Blood?** _____
6. **Prostate Exam?** _____
7. **Colonoscopy?** _____
8. **Bone Density?** _____

Thank you for filling this important form out and for choosing Internal Medicine Associates of Johns Creek.