Internal Medicine
Associates of the Grand Valley
Community HOSPITAL

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Patient's Personal History

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Date:

Last Name:	First:	Middle:
Doctor:	Home Phone:	Cell Phone:

PERSONAL HABITS: (Circle)

Yes No Do you regularly smoke? Cigarettes Pipe Cigars For how many years? _____
Yes No Do you usually drink over 6 cups of coffee per day?
Yes No Do you regularly drink alcohol? 1oz per day 2 oz per day 4 oz per day over 6 oz
Yes No BEER: 1 Bottle per day 2 Bottles per day Over 4 bottles per day
Yes No Substance use? _____
Yes No Do you use seat belts?
Yes No Do you exercise regularly? How often? _____
Yes No Do you have a living will, or other advance directive?

CURRENT MEDICATIONS: (Please indicate dosage and frequency)

_____

_____

IMMUNIZATIONS	Date of last immunization
Pneumovax (Pneumonia)	
Hepatitis A	
Hepatitis B	
Zostavax	
Tetanus	

Family History			If Living	If Deceased	
	Sex	Age	Any Health Conditions	Cause of Death	Age at Death
Father					
Mother					
Brother/Sisters					
Husband/Wife					
Children					

Patient Name: _____

Do you know of any relative who has had any of the following? (Circle and give relationship)

Stroke _____	Epilepsy_____	Heart Attack_____	Leukemia_____
Cancer _____	Suicide_____	Stomach Ulcers _____	Rheumatic Heart _____
High Blood Pressure_____	Migraine Headaches_____	Kidney Disease _____	Nervous Breakdown _____
Tuberculosis _____	Asthma _____	Goiter _____	Colitis _____
Diabetes _____	Hay Fever_____	Arthritis_____	Congenital Heart _____
Bleeding Tendency_____	Mental Illness _____		

* * * * * * * * *

Write in the names of any operations that you have had:

_____

_____

_____

Name any drugs to which you are allergic:

_____

_____

_____

Write in the names of any diseases you have had which required hospitalization:

_____

_____

_____

Write in the names of any serious illness you have had (not requiring hospitalization):

_____

_____

_____

Write in any serious injuries or accidents that you have had.

_____

_____

Patient Name: _____

TO BE ANSWERED BY WOMEN ONLY: (Circle)

Yes No Are you still having regular monthly menstrual periods?
Yes No Have you had bleeding between your periods? When? _____
Yes No Do you have very heavy bleeding with your periods? When? _____
Yes No Do you feel bloated and irritable before your period?
Yes No Are you now or have you taken the birth control pill? When? _____
Yes No Have you had a miscarriage? When? _____
Yes No Have you had discharge from the nipple of your breast? When? _____
Yes No Date of last cancer test of the cervix? _____

How many live births? _____
How many stillbirths? _____
How many premature births? _____
Date of last menstrual period: _____
Date of last Bone Density? _____

How many miscarriages? _____
How many cesarean operations? _____
Any complications during pregnancy? _____
Date of last mammogram? _____

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TO BE ANSWERED BY MEN ONLY: Since your last exam, have you had (Circle)

Yes No Treatment for genitals (private parts) Yes No Hernia (Rupture)?
Yes No Discharge from penis? Yes No Prostate trouble?

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TO BE ANSWERED BY MEN AND WOMEN: (Circle)

Yes No Severe Headaches? Yes No Does aspirin relieve them?
Yes No Visual trouble? Yes No Do they feel like a tight headband?
Yes No Do the headaches awaken you frequently at night?
Yes No Do they occur on the side of the head?
Yes No Do they hurt most in the back of the head and Neck?
Yes No Fainted? Yes No A convulsion?
Yes No Spells of dizziness? Yes No Double vision?
Yes No Spells of weakness in an arm or leg? Yes No Pains in the ear?
Yes No Ringing in the ears? Yes No Have you had nosebleeds?

Patient Name:_____

Shortness of breath… (Circle)

Yes	No	Doing your usual work?	Yes	No	Which causes you to cough?
Yes	No	Climbing a flight of stairs?	Yes	No	Accompanied by wheezing?
Yes	No	Which awakens you at night?	Yes	No	Which causes you to cough blood?
Yes	No	Do you have a chronic cough?	Yes	No	Which causes you to cough up sputum?

Chest pain or tightness in the chest that begins… (Circle)

Yes	No	When exerting yourself?	Yes	No	Radiates down the arm?
Yes	No	When walking against the wind?	Yes	No	Disappears if you rest?
Yes	No	When walking up a hill?	Yes	No	Occurs only at rest?
Yes	No	After a heavy meal?	Yes	No	When walking fast?
Yes	No	When upset or excited?	Yes	No	When walking in cold weather?
Yes	No	Do you have palpitations?	Yes	No	Do you sleep on more than one pillow?

If you have chest pain or tightness, please explain. _____

_____

_____

Pain in the stomach that…(Circle)

Yes	No	Occurs 1-2 hours after a meal?	Yes	No	Is relieved by antacid medications?
Yes	No	Awakens you at night?	Yes	No	Is relieved with milk or eating?
Yes	No	Occurs while eating or immediately after?	Yes	No	Is relieved by a bowel movement?
Yes	No	Is brought on by eating fried, gassy foods?	Yes	No	Do you notice a loss of appetite?
Yes	No	Crampy pain in abdomen:	Yes	No	Blood in the stool?
Yes	No	Alternating diarrhea and constipation?	Yes	No	Ribbon-like stool?
Yes	No	Pain during or after bowel movement?	Yes	No	Black stools?
Yes	No	Mucous in stool?	Yes	No	Require use of strong laxatives or enema?

Date of last Colonoscopy: _____

Yes	No	Burning when urinating?	Yes	No	Loss of control of bladder?
Yes	No	Blood in urine?	Yes	No	Dark colored urine?
Yes	No	Trouble starting to urinate?	Yes	No	Trouble holding the urine?
Yes	No	Getting up frequently at night?	Yes	No	Passing of a kidney stone?
Yes	No	Decreased sexual functions?			

Yes	No	Pains in calves or legs when walking?	Yes	No	Cramps in legs at night?
Yes	No	Pain in the big toe?	Yes	No	Varicose veins?
Yes	No	Phlebitis or inflamed leg veins?	Yes	No	Swelling in the ankles?

Briefly describe your present medical concerns to discuss with the doctor_____

_____

_____