

Internal Medicine

Associates of the Grand Valley



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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? CigarettesPipe 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? _____

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?

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 _____

