Internal Medicine
Associates of the Grand Valley
Community HOSPITAL

Patient Health History

Provider you are scheduled to see:

□ Barry Holcomb, MD □ Donald Maier, MD □ David Johansen, MD
□ Florian Seeberger, MD □ Randall C. Coffey, MD □ Kirsten Wiegert, NP

Date: _____

Name: _____ **Date of Birth:** _____

Please briefly describe the medical concerns you would like to discuss with your provider:

_____

_____

Please circle the answer that applies the most to you:

Yes	No	Do you currently use tobacco products (vape, smoke, chew)?
Yes	No	Have you used tobacco previously? If yes, when did you quit? _____
Yes	No	Do you use marijuana or cannabis products in any form (smoking, caping, edibles, creams, etc.)?
Yes	No	Do you use illicit drugs or substances? If yes, what substances? _____
Yes	No	Have you fallen in the past six months?
Yes	No	Do you worry about falling?
Yes	No	Do you feel safe at home?
Yes	No	Do you have a living will, medical power of attorney or other advance directive?

How often do you have a drink containing alcohol?

a. Never
b. Monthly or less
c. 2 - 4 times a month
d. 2 - 3 times a week
e. 4 or more times a week

How many drinking containing alcohol do you have containing alcohol on a typical day?

a. 0 - 2 drinks a day
b. 3 - 4 drinks a day
c. 5 - 6 drinks a day
d. 7 - 9 drinks a day
e. 10 or more drinks a day

How often do you have six or more drinks on one occasion?

a. Never
b. Less than monthly
c. Monthly
d. Weekly
e. Daily or almost daily

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Immunization History

Immunization/Vaccine History	Date
Flu Vaccine	Did you get an annual flu vaccine? Yes No
Prevnar 13 (Pneumonia)	
Pneumovax 23 (Pneumonia)	
Most Recent Td or Tdap (Tetanus)	
Shingrix (Shingles)	
Hepatitis A	
Hepatitis B	

Specialty	Name of Provider
Previous Primary Care Provider	
Dentist	

Please circle the answer that applies the most to you:

Yes	No	Leg swelling
Yes	No	Shortness of breath when laying down
Yes	No	Pains in calves or legs when walking
Yes	No	Trouble swallowing
Yes	No	Acid reflux/heartburn
Yes	No	Blood in the stool or black tarry stools
Yes	No	Frequent or chronic diarrhea
Yes	No	Frequent or chronic constipation
Yes	No	Burning when urinating
Yes	No	Blood in urine
Yes	No	Trouble starting urination
Yes	No	Getting up frequently at night to urinate
Yes	No	Loss of bladder control
Yes	No	Difficulty with sexual functions
Yes	No	Difficulty sleeping
Yes	No	Do you snore?
Yes	No	Frequently and/or unintentionally falling asleep during the day

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Please circle the answer that applies the most to you:

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3

Do you have any difficulty with affording food, housing, medications, transportation, utility bills or other concerns and would like to seek help from a case manager?

Yes No

In the past six months have you experienced any of the following symptoms::

Yes	No	Recurrent fevers
Yes	No	Unintentional weight loss of weigh gain
Yes	No	Severe headaches
Yes	No	Fainted or lost consciousness
Yes	No	Spells of dizziness
Yes	No	Changes in your vision
Yes	No	Trouble with hearing
Yes	No	Concerns with teeth
Yes	No	Abnormal/worrisome skin lesions
Yes	No	Rash
Yes	No	Chronic cough
Yes	No	Shortness of breath
Yes	No	Wheezing
Yes	No	Chronic hoarseness
Yes	No	Chest pain
Yes	No	Palpitations/irregular heart beats

Men, please complete this portion:

Yes	No	Discharge from penis
Yes	No	Prostate concerns
Yes	No	Testicle concerns

Age 50-79: Date of most recent prostate cancer screening (PSA): _____

Age 65-75 & former smokers: Date of most recent abdominal aortic aneurysm screening: _____

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Women, please complete this portion:

Yes	No	Are you still having menstrual periods? If no, age of menopause: _____
Yes	No	Are you using birth control? If yes, which form of birth control: _____
Yes	No	Are you having abnormal vaginal bleeding? (Bleeding after menopause, etc.)
Yes	No	Have you had discharge from the nipple of your breasts?
Yes	No	Have you noticed any masses in your breasts?

Age 40+: Date of most recent breast cancer screening (mammogram): _____

Age 21-65: Date of most recent cervical cancer screening (pap smear): _____

Post Menopause: Date of most recent bone density screening (DEXA): _____

Men & women, please complete this portion:

Yes	No	Would you like a screening test for HIV?
Yes	No	Would you like a screening test for other sexually transmitted diseases?

Age 50+: Date of most recent colon cancer screening (colonoscopy or stool test): _____

Individuals born between 1945-1965: Date of most recent hepatitis C screening test: _____

Please list any surgical operations you have had:

_____

_____

_____

Please list any serious illness or medical conditions you have had:

_____

_____

_____

Please list any serious injuries or accidents you have had:

_____

_____

_____

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Medications - Please list both prescription & over-the-counter medications

Medication	Dosage & Frequency

Allergies - Please list all allergies, both medical and other

Allergy	Reaction

Family History

	Sex	Age	Health Conditions	If Deceased, Casued of Death	Age at Death
Father					
Mother					
Siblings					
Children					

Please list any cancers or health conditions that your family has history of:

_____

_____