

MEDICAL HISTORY Inter Island Medical Center

NAME: First _____ MI Last _____ **Date of Birth** _____

Single _____ Married/Partner _____ Divorced _____ Widower _____ Education (yrs): High School _____
 (circle one) College _____ Other _____

HEIGHT _____ WEIGHT _____ WT at age 20 _____ WT (gain/loss) in past year _____ Desired Weight _____
 Occupation: _____

DATE OF LAST: tetanus shot _____ flu shot _____ physical _____ dental exam _____ pap smear _____ mammogram _____

SURGERIES (circle) DATE

hysterectomy _____
 hernia _____
 gallbladder _____
 appendectomy _____
 breast surgery _____
 c-section _____
 other _____

ILLNESSES / INJURIES (circle)

hypertension _____ glaucoma _____
 diabetes _____ thyroid _____
 epilepsy _____ substance abuse _____
 asthma/allergies _____ domestic violence _____
 heart attack/stroke _____ bladder/kidney problem _____
 depression/anxiety _____ ulcer/stomach problem _____
 hepatitis (A,B,C) _____ accidents _____
 cancer _____ other _____

ALLERGIES: _____

FAMILY HISTORY	<u>Age</u>	<u>Age at Death / Cause</u>
Father	_____	_____
Mother	_____	_____
Brother/Sister	_____	_____
	_____	_____
Children	_____	_____
	_____	_____
	_____	_____

HAS ANY BLOOD RELATIVE EVER HAD:
 (Specify who)

asthma/allergies _____
 glaucoma _____
 cancer/type _____
 diabetes _____
 heart trouble _____
 high blood pressure _____
 stroke _____
 substance abuse _____
 thyroid problem _____
 colon cancer/colitis _____
 ulcers/stomach trouble _____

WHO LIVES IN YOUR HOUSEHOLD? _____

HABITS (Circle all that apply)

ALCOHOLIC DRINKS:
 never _____ 1-2 per month _____ 1-2 per week _____
 1-2 daily _____ 3 or more daily _____

CIGARETTES: _____ packs per day
 cigars _____ pipes _____ chewing tobacco _____ snuff _____
 year quit _____ # yrs smoked _____

COFFEE / TEA / SODA: _____ per day

DRUGS USED: (now / past)
 marijuana _____ cocaine _____ heroine _____ speed _____
 other _____

EXERCISE:
 Type _____
 days per week _____ minutes per day _____

PRESCRIPTION MEDS & DOSAGES:

NON-PRESCRIPTION DRUGS, VITAMINS, HERBS, ETC

Please Complete Both Pages of Form. Thank You!

CURRENT PROBLEMS OR CONCERNS:

(How long has this been a problem)

BODY SYSTEMS REVIEW: (Check any item that you are experiencing to any significant degree)

_____ unexplainable fatigue	_____ chronic cough	_____ heartburn
_____ recurring fever/chills	_____ cough blood	_____ ulcer
_____ swollen glands	_____ pneumonia	_____ irritable bowel
_____ night sweats	_____ short of breath	_____ black or bloody stools
_____ weakness	_____ wheezing	_____ rectal bleeding
_____ weight problem		_____ abdominal pain
	_____ chest pain	_____ constipation/diarrhea
_____ unconsciousness	_____ heart murmur	_____ loss of appetite
_____ frequent/severe headaches	_____ palpitations	_____ change in bowel habits
_____ fainting	_____ rheumatic fever	_____ hemorrhoids
_____ dizzy spells	_____ swollen ankles/feet	
_____ seizures	_____ leg pain with walking	_____ psoriasis
_____ head injury	_____ varicose veins	_____ eczema
_____ paralysis	_____ blood clots	_____ changing moles
	_____ anemia	_____ skin cancer
	_____ blood disease	
_____ trouble concentrating		_____ ear/hearing problem
_____ memory problems	_____ bladder/kidney	_____ eye/vision problem
_____ tense/irritable	_____ infection	_____ glaucoma
_____ trouble sleeping	_____ difficulty urinating	_____ cataracts
_____ feel depressed	_____ frequent urination	_____ seasonal allergies
_____ work or family problems	_____ leaking urine	_____ sinus trouble
_____ thoughts about suicide	_____ kidney stone	_____ dental problems
_____ seeing a counselor	_____ infertility	_____ persistent hoarseness
	_____ sexual difficulties	_____ trouble swallowing
_____ knee/ankle problem	_____ prostate problems	_____ thyroid problem
_____ shoulder/elbow problem	_____ penile discharge	
_____ arthritis/joint pains	_____ lump on testicle	
_____ back/neck trouble	_____ urinate at night _____ time(s)	
_____ numbness/tingling		

WOMEN ONLY: Menstrual History

age of onset _____	painful intercourse? _____	number of pregnancies _____
length of cycle _____	previous sexual abuse? _____	number of children _____
days of flow _____	do you perform self breast exam? _____	type of birth control you use _____
days of last period _____	breast lump or cyst? _____	history of abnormal pap? _____
periods painful? _____	menopausal symptoms? _____	
unusual discharge? _____	taking/taken hormones? _____	
family history of osteoporosis / breast / cervical / uterine cancer? _____		

NUTRITION: HOW MANY SERVINGS OF THE FOLLOWING FOODS DO YOU EAT?

PER DAY: meals _____ snacks _____ total cups of fluids _____ cups of milk _____
 breads & starches _____ fruits & vegetables _____

PER WEEK: eggs _____ red meats _____ cheeses _____ fish _____ fried foods _____
 desserts _____ chips / snack foods _____

SIGNATURE _____ **DATE** _____