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INTERNAL MEDICINE
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PLEASE COMPLETE IN INK

Today's Date: _____
Patient Account #: _____
PATIENT NAME: _____
Referring Physician: _____
Other Treating Physicians: _____

Date of Birth: _____ **Age:** _____ **Height:** _____ **Weight:** _____

MEDICAL HISTORY:

- ☐ No Medical Problems
- ☐ DEXA Scan or Bone Density Scan
- ☐ History of MRSA
- ☐ Claustrophobic or fearful of enclosed spaces
- ☐ Diabetes, Insulin-Requiring
- ☐ Diabetes, Non-Insulin
- ☐ Bleeding Disorder
- ☐ Pulmonary Embolism (Blood Clot Lung)
- ☐ Deep Vein Thrombosis (Blood Clot Leg)
- ☐ Hypothyroidism
- ☐ HIV or AIDS
- ☐ Leukemia or Lymphoma
- ☐ Organ Transplant
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ Heart Arrhythmia
- ☐ Pacemaker
- ☐ Heart
- ☐ Stroke or Ministroke
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Emphysema or COPD
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Peripheral Vascular Disease
- ☐ Hiatal Hernia/Reflux Disease
- ☐ Peptic Ulcer Disease
- ☐ Diverticulitis
- ☐ Urinary Tract Infections
- ☐ Kidney Stones
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Seizure Disorder
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Rheumatoid Disease
- ☐ Migraine Headaches
- ☐ Cancer (type) _____
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Psoriasis or Other Skin Disease
- ☐ Poliomyelitis
- ☐ Psychiatric Disorder
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Drug Addiction
- ☐ Glaucoma

Please list any other conditions not mentioned above: _____

PAST SURGICAL HISTORY: Please list any operations you have had in the past & date or approximate age at time of procedure

	Date or Age
☐ No Previous Surgery	
☐ Prior Orthopedic Surgery	
☐ Hand Surgery	
☐ Knee Surgery	
☐ Fracture	
☐ Shoulder Surgery	
☐ Spine Surgery	
☐ Total Hip Arthroplasty	
☐ Total Knee Arthroplasty	
☐ General Surgery	
☐ Appendectomy	
☐ C-Section	
☐ Gallbladder	
☐ Hernia Repair	
☐ Hysterectomy	
☐ Other Surgery	
☐ Tonsillectomy/Adenoidectomy	
☐ Wisdom Teeth Extraction	

Please list any additional surgeries:

Operation	*Date or Age*

MEDICATIONS: Please list all medications or drugs including birth control pills, over-the-counter medications or herbal supplements you are currently taking

Drug or Medicine	*Amount/Dose*	*Start Date*	*Stop Date*	*Stop Reason*

ALLERGIES: Please list all medications, metals, dyes, latex or foods. If you have a paper list of your medications or allergies, we will make a photocopy of them. **If you don't have any allergies, please write NONE under Allergy List**

Allergy List	*Reaction*

FAMILY HISTORY: Do any of these diseases run in your immediate family (parents, sisters, brothers)?

☐ No Medical Conditions ☐ Cancer ☐ Heart Disease ☐ Rheumatoid Arthritis
☐ Asthma ☐ Diabetes Insulin Dependent ☐ High Blood Pressure ☐ Stroke
☐ Back Problems ☐ Diabetes Non-Insulin Dependent ☐ Orthopaedic Problems ☐ Other _____

SOCIAL HISTORY:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Living with Significant Other
Number of children? _____

Do you smoke? ☐ Yes ☐ No
If yes, how many packs a day? _____ If yes, age started _____
If you are a past smoker, when did you quit & amount previously smoked? _____ _____
Do you use chewing tobacco? ☐ Yes ☐ No If yes, how many tins/pouches? _____ How many years? _____

Do you use alcohol? ☐ Yes ☐ No
Occasional ☐
Moderate ☐
Heavy ☐

Do you use caffeine? ☐ Yes ☐ No
Occasional ☐
Moderate ☐
Heavy ☐

Abused Prescription Drugs ☐ _____
Used Recreational Drugs ☐ _____
Used Anabolic Steroids ☐ _____
Used Other Performance Enhancing Substances ☐ _____

Do you exercise? ☐ Yes ☐ No
Occasional ☐
Moderate ☐
Heavy ☐

Recreational Activities (sports, hunting, fishing, gardening hobbies, etc.)

Education
☐ Less than 8th Grade
☐ 8th Grade
☐ 9th Grade
☐ 10th Grade
☐ 11th Grade
☐ 12th Grade
☐ 2 Year College
☐ 4 Year College
☐ Post Graduate

OCCUPATIONAL HISTORY:

Employer: _____
What is your primary occupation (if not working, what was your primary occupation)? _____
How many years have you been with your current employer? _____
If not working, how long has it been since you stopped? _____
What statement describes your current employment situation (check all that apply)? ☐ Retired (not due to health)
☐ Currently Working ☐ Unemployed ☐ Homemaker ☐ On Unpaid Leave ☐ On Paid Leave ☐ Disabled

Is there litigation in process pertaining to your symptoms? ☐ Yes ☐ No

Date: _____

Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS: Have you had any of the following in the past six (6) months?

CONSTITUTIONAL *(General)*
Constitutional: ☐ none, ☐ fever, ☐night sweats, ☐weight gain (____lbs), ☐weight loss (____ lbs), ☐exercise intolerance

EYES
Eyes: ☐none, ☐dry eyes, ☐irritation, ☐vision change

ENMT *(Ears, Nose, Mouth, Throat)*
Ears: ☐none, ☐difficulty hearing, ☐ear pain
Nose: ☐none, ☐frequent nosebleeds, ☐nose/sinus problems
Mouth/Throat: ☐none, ☐sore throat, ☐bleeding gums, ☐snoring, ☐dry mouth, ☐oral abnormalities, ☐mouth ulcer, ☐teeth abnormalities, ☐mouth breathing

CARDIOVASCULAR
Cardiovascular: ☐none, ☐chest pain on exertion, ☐arm pain on exertion, ☐shortness of breath when walking, ☐shortness of breath when lying down, ☐palpitations, ☐known heart murmur, ☐light-headed on standing

RESPIRATORY
Respiratory: ☐none, ☐wheezing, ☐shortness of breath, ☐coughing up blood, ☐sleep apnea

GASTROINTESTINAL
Gastrointestinal: ☐none, ☐abdominal pain, ☐vomiting, ☐change in appetite, ☐black or tarry stools, ☐frequent diarrhea, ☐ vomiting blood

GENITOURINARY
Genitourinary: ☐none, ☐urinary loss of control, ☐difficulty urinating, ☐increased urinary frequency, ☐hematuria *(blood)*, ☐ incomplete emptying

MUSCULOSKELETAL
Musculoskeletal: ☐none, ☐muscle aches, ☐muscle weakness, ☐arthralgias/joint pain, ☐back pain

INTEGUMENTARY *(Skin)*
Skin: ☐none, ☐abnormal mole, ☐jaundice, ☐eczema, ☐rash, ☐itching, ☐dry skin, growths/lesions

NEUROLOGIC
Neurologic: ☐none, ☐loss of consciousness, ☐weakness, ☐numbness, ☐seizures, ☐dizziness, ☐frequent or ☐severe headaches☐, migraines, ☐restless legs

PSYCHIATRIC
Psych: ☐none, ☐depression, ☐mania, ☐sleep disturbances, ☐restless sleep, ☐feeling unsafe in relationship, ☐alcohol abuse

ENDOCRINE
Endocrine: ☐none, ☐fatigue, ☐increased thirst, ☐hair loss, ☐increased hair growth, ☐cold intolerance

HEMATOLOGIC/LYMPHATIC
Hematologic/Lymphatic: ☐none, ☐swollen glands, ☐easy bruising, ☐excessive bleeding

ALLERGIC/IMMUNOLOGIC
Allergy/Immunologic: ☐none, ☐runny nose, ☐sinus pressure, ☐itching, ☐hives, ☐frequent sneezing