

Patient Name _____ Date of Birth _____

Blairsville Internal Medicine Health History Questionnaire

Your answers will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. INFORMATION IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit _____

Other concerns _____

REVIEW OF SYSTEMS Please check all that apply:

Constitutional Exercise Intolerance Fatigue Fever Weight Gain (____lbs) Weight Loss (____lbs) Other _____

Eyes Dry Eyes Irritation Vision Change Date of Last Exam: _____ Other _____

Ears/Nose/Mouth/Throat Bleeding Gums Difficulty Hearing Dizziness Dry Mouth Ear Pain Frequent Infections
 Frequent Nosebleeds Hoarseness Mouth Breathing Mouth Ulcers Nose/Sinus Problems Ringing in Ears
 Other _____

Cardiovascular Arm Pain on Exertion Chest Pain on Exertion Chest Heaviness/Pressure on Exertion Irregular Heart Beats (Palpitations)
 Known Heart Murmur Light-headed on Standing Shortness of Breath When Lying Down Shortness of Breath When Walking
 Swelling (edema) Other _____

Respiratory Cough Coughing Up Blood Shortness of Breath Sleep Apnea Snoring Wheezing Other _____

Gastrointestinal Abdominal Pain Black or Tarry Stool Blood in Stool Change in Appetite Frequent Indigestion Hemorrhoids
 Trouble Swallowing Vomiting Vomiting Blood Other _____

Genitourinary Blood in Urine Difficulty Urinating Incomplete Emptying Increased Urinary Frequency Urinary Loss of Control
 Wake in the night to go to the bathroom Other _____

Female: Bleeding between periods Heavy periods Extreme menstrual pain Vaginal itching, burning, or discharge
 Hot flashes Breast lump or nipple discharge Painful intercourse Other _____

Musculoskeletal Back Pain Joint Pain Muscle Aches Muscle Weakness Other _____

Integumentary (Skin) Changes in Moles Dry Skin Eczema Growth/Lesions Itching Jaundice (Yellow Skin/Eyes) Rash
 Other _____

Neurological Dizziness Fainting Headaches Memory Loss Migraines Numbness Restless Legs Seizures Weakness
 Other _____

Psychiatric Alcohol Overuse Anxiety/Stress Depression Do Not Feel Safe in Relationship Mania Sleep Problems
 Other _____

Endocrine Fatigue Increased Thirst/Hunger/Urination Other _____

Hematologic/Lymphatic Easy Bruising/Bleeding Swollen Glands Other _____

Allergic/Immunologic Frequent Sneezing Hives Itching Runny Nose Sinus Pressure Other _____

PAST MEDICAL HISTORY Please check all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Leg/Foot Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood Clots / DVT / Pulmonary Embolism | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Cancer type _____ | <input type="checkbox"/> GERD (acid reflux) / Hiatal Hernia | <input type="checkbox"/> Pre-Diabetes |
| <input type="checkbox"/> COPD | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Alzheimer's / Dementia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes - Insulin | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Thyroid <input type="checkbox"/> Overactive <input type="checkbox"/> Underactive |
| <input type="checkbox"/> Diabetes – Non-Insulin | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Other _____ | | |

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(Women Only) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ Abnormal Declined Not Done
Last Mammogram Date _____ Abnormal Declined Not Done
Age of first menstrual period _____ Date of last menstrual period or age of menopause _____
Number of pregnancies _____ Births _____ Cesarean sections If yes, then number _____
Miscarriages _____ Abortions _____

PAST SURGICAL HISTORY and PAST HOSPITALIZATION(S)

1. _____ Reason _____ Year _____ Hospital _____
2. _____ Reason _____ Year _____ Hospital _____
3. _____ Reason _____ Year _____ Hospital _____
4. _____ Reason _____ Year _____ Hospital _____
5. _____ Reason _____ Year _____ Hospital _____

SOCIAL HISTORY

Occupation _____ Currently employed? Yes No Retired On disability (reason) _____

Education Less than 8th grade High school 2 year college 4 year college Post graduate
Any barriers to learning? Vision Hearing Unable to Read Other _____
Primary Language _____ Do you need an interpreter? Yes No

Marital Status Married Single Divorced Separated Widowed Domestic partner

Diet Regular Vegetarian/Vegan Diabetic Cardiac Gluten Free Other _____

Exercise Type _____ Frequency _____ Duration _____ (mins)

Caffeine None Occasional Moderate Heavy Number of cups/cans per day? _____

Alcohol Do you drink alcohol? Yes No Do you have a history of Alcohol Abuse Alcoholism
How often do you consume alcohol? Occasionally < 3 times a week > 3 times a week How many drinks per week? _____
How many days in the past year have you had heavy drinking consumption (4+ female, 5+ male)? _____

Tobacco Do you use tobacco? Yes # of years _____ No Or year quit _____
If not currently, did you ever use tobacco? Yes No
 Cigarettes - _____ pks./day Cigars - _____/day Vape - _____/day Chew - _____/day

Drugs Do you currently use recreational or street drugs? Yes No
If yes, list: _____

Sexual Activity Are you currently sexually active? Yes No, not active since _____
Current or past sexual partner(s) include Female Male Female and Male
Do you have a history of physical, sexual or emotional abuse? Yes No
Do you use condoms? Yes No Other Birth control method used: _____
Are you interested in being screened for Sexually Transmitted Diseases (STDs)? Yes No
Have you been screened for Hepatitis C? Yes No Date _____

Housing Do you live at home, alone at home with spouse or other family in Assisted Living Facility
Do you feel safe at home? Yes No Reason _____

FAMILY HEALTH HISTORY

Grandmother (maternal) Alive Y / N Age _____ Cancer (type) _____ Diabetes Heart disease / Stroke
 Hypertension Other _____
Grandfather (maternal) Alive Y / N Age _____ Cancer (type) _____ Diabetes Heart disease / Stroke
 Hypertension Other _____
Grandmother (paternal) Alive Y / N Age _____ Cancer (type) _____ Diabetes Heart disease / Stroke
 Hypertension Other _____
Grandfather (paternal) Alive Y / N Age _____ Cancer (type) _____ Diabetes Heart disease / Stroke
 Hypertension Other _____
Father Alive Y / N Age _____ Cancer (type) _____ Diabetes Heart disease / Stroke
 Hypertension Other _____

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Mother Alive Y / N Age _____ Cancer (type) _____ Diabetes Heart disease / Stroke
 Hypertension Other _____

Brother/Sister Alive Y / N Age _____ Cancer (type) _____ Diabetes Heart disease / Stroke
 Hypertension Other _____

Brother/Sister Alive Y / N Age _____ Cancer (type) _____ Diabetes Heart disease / Stroke
 Hypertension Other _____

Other _____ Alive Y / N Age _____ Cancer (type) _____ Diabetes Heart disease / Stroke
 Hypertension Other _____

MEDICATIONS Check Primary Pharmacy Local _____ (city) _____ Mail-order _____
Please list all your medications; include prescriptions, over-the-counter drugs, vitamins, inhalers, diabetic test strips, etc.

1. _____ Strength _____ Frequency _____
2. _____ Strength _____ Frequency _____
3. _____ Strength _____ Frequency _____
4. _____ Strength _____ Frequency _____
5. _____ Strength _____ Frequency _____
6. _____ Strength _____ Frequency _____
7. _____ Strength _____ Frequency _____
8. _____ Strength _____ Frequency _____
9. _____ Strength _____ Frequency _____
10. _____ Strength _____ Frequency _____
11. _____ Strength _____ Frequency _____
12. _____ Strength _____ Frequency _____
13. _____ Strength _____ Frequency _____
14. _____ Strength _____ Frequency _____
15. _____ Strength _____ Frequency _____
16. _____ Strength _____ Frequency _____
17. _____ Strength _____ Frequency _____
18. _____ Strength _____ Frequency _____
19. _____ Strength _____ Frequency _____
20. _____ Strength _____ Frequency _____

ALLERGIES: List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

1. _____ Reaction _____
2. _____ Reaction _____
3. _____ Reaction _____

IMMUNIZATION HISTORY Please give most recent date of administration or indicate if vaccination was Declined.

- Chickenpox Date _____ Declined
- Flu Shot Date _____ Declined
- Gardasil/HPV Date _____ Declined
- Hepatitis A Date _____ Declined
- Hepatitis B Date _____ Declined
- Meningococcus Date _____ Declined
- MMR (*Measles, Mumps, Rubella*) Date _____ Declined
- Pneumonia Pneumovax 23 Date _____ Declined Prevnar 13 Date _____ Declined
- Shingles Zostavax Date _____ Declined Shingrix Date(s) _____ Declined
- Tdap (*Tetanus and pertussis*) Date _____ Declined
- I choose NOT to take vaccinations.

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HEALTH MAINTENANCE

Advance Directive / Living Will / POLST Yes, please bring copy to include in your medical record. No
Medical Power of Attorney? Yes No Name _____ Phone _____
Code Status Full (CPR, intubation & mechanical ventilation, cardioversion) Do Not Resuscitate Other _____
Blood transfusion okay in an emergency? Yes No Dialysis okay? Yes No

Annual Physical Yes Date _____ No Medicare Wellness Exam Yes Date _____ No Declined

Colon Cancer Screening Colonoscopy Yes Results _____ Date _____ repeat due _____ No Declined
Cologuard Yes Date _____ No Declined Fecal Occult Blood Test (card) Yes Date _____ No Declined

Have you ever had a bone density screening? Yes Results _____ Date _____ No Declined

Have you ever had an Aortic Aneurysm Screening (Ultrasound)? Yes Results _____ Date _____ No Declined

Are you diagnosed as Pre-diabetic (borderline) or Diabetic? If so, please answer the following.

Last A1C result _____ Date _____ Last Microalbumin result _____ Date _____

Last Diabetic Foot Exam Date _____ Last Dilated Eye Exam Date _____ Results _____ By _____

Last LDL Cholesterol result _____ Date _____ Are you currently taking a statin drug? Yes No Declined

Have you had reaction to a statin drug? Yes No Name(s) _____ Reaction _____

If you are diagnosed with Hypertension, please list Blood Pressure readings for last 10 days:

- 1. Date _____ Time _____ AM / PM Reading _____ / _____
- 2. Date _____ Time _____ AM / PM Reading _____ / _____
- 3. Date _____ Time _____ AM / PM Reading _____ / _____
- 4. Date _____ Time _____ AM / PM Reading _____ / _____
- 5. Date _____ Time _____ AM / PM Reading _____ / _____
- 6. Date _____ Time _____ AM / PM Reading _____ / _____
- 7. Date _____ Time _____ AM / PM Reading _____ / _____
- 8. Date _____ Time _____ AM / PM Reading _____ / _____
- 9. Date _____ Time _____ AM / PM Reading _____ / _____
- 10. Date _____ Time _____ AM / PM Reading _____ / _____

If you have a copy of lab results, please provide for your medical record. If not, please contact last doctor and ask results be sent to our office. If you routinely see another doctor who performs lab tests, please be sure they forward copies of current and future results. Appointments WILL NOT be scheduled until after results are received.

Previous Primary Care Provider _____ Specialty _____ Phone _____
Reason for changing provider _____

Specialist Provider(s). Name _____ Specialty _____ Phone _____
Name _____ Specialty _____ Phone _____
Name _____ Specialty _____ Phone _____
Name _____ Specialty _____ Phone _____

The information above is accurate, to the best of my knowledge.

Printed Name of Patient _____ Date of Birth _____

Printed Name of Guardian _____ Telephone _____

Guardian is Spouse Parent Other family _____ Caregiver has Power of Attorney (please, provide copy)

Signature of Patient, Guardian or Legal Representative Date Signed _____