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.

Patient Name _____ **Date of Birth** _____

Main reason for today's visit _____

Other concerns _____

REVIEW OF SYSTEMS Please check all that apply: 266800158

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:

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

☐ Other _____

References to "the practice(s)" in this document include Mary Beth Wiles, MD, PC; Mary Elizabeth Wiles, DO, PC; Blairsville Internal Medicine and all providers.
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(Women Only) OBSTETRIC 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_____ ☐# _____pks/day ☐ 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 _____

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 _____

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
☐ Prevnar 20 Date _____ ☐ Declined
☐ Covid Shot Brand _____ 1st Date _____ ☐ Declined 2nd Date _____ ☐ Declined
☐ Covid Booster Date _____ ☐ Declined ☐ Covid Booster Date _____ ☐ Declined
☐ Shingles ☐ Zostavax Date _____ ☐ Declined ☐ Shingrix Date(s) _____ ☐ Declined
☐ Tdap (*Tetanus and pertussis)* Date _____ ☐ Declined

☐ I choose NOT to take vaccinations.

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 _____

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)

_____ Date Signed _____
Signature of Patient, Guardian or Legal Representative