Advanced Internal Medicine Group, PC

PATIENT MEDICAL HISTORY FORM

Patient Name:____ **Date of Birth:**____________

Patient Maiden Name or Former Name:____

Date:____ **Physician:**___________________________

How did you hear about AIM Health?____

Are there any specialists you see?____

PAST MEDICAL HISTORY: (Check conditions and illnesses for which you have been treated and include year of onset. List any other conditions which may not be included below.)

☐ No known medical problems
☐ Anemia___________________
☐ Anesthesia complications_____
☐ Anxiety__________________
☐ Arthritis_________________
☐ Asthma__________________
☐ Blood transfusion__________
☐ Cancer (list type below)______
☐ Cataracts________________
☐ CHF_____________________
☐ COPD____________________
☐ Depression_________________
☐ Diabetes mellitus____________
☐ Emphysema_________________
☐ Environmental allergies_______
☐ GERD_____________________
☐ Glaucoma__________________
☐ Heart murmur______________
☐ HIV/AIDS__________________
☐ Hyperlipidemia______________
☐ Hypertension_______________
☐ Kidney disease______________
☐ Meningitis________________
☐ MI (Heart Attack)__________
☐ Nerve/Muscle disease______
☐ Osteoporosis______________
☐ Seizures__________________
☐ Sickle cell anemia__________
☐ Stroke/TIA________________
☐ Substance abuse___________
☐ Thyroid disease____________
☐ Tuberculosis/TB___________

Additional information/other history:____

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PAST SURGICAL HISTORY: (Indicate year)

☐ No prior surgeries
☐ Appendectomy_____________
☐ Brain surgery______________
☐ CABG____________________
☐ Cholecystectomy___________
☐ Colon surgery______________
☐ Cosmetic surgery___________
☐ C-section_________________
☐ Eye surgery________________
☐ Fracture surgery____________
☐ Hernia repair_______________
☐ Joint replacement___________
☐ Prostate surgery____________
☐ Hysterectomy______________
☐ Tubal ligation______________
☐ Small intestine surgery______
☐ Spine surgery______________
☐ Tonsillectomy_____________
☐ Valve replacement_________
☐ Vasectomy________________
☐ Breast surgery_____________

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☐ Other surgeries and/or hospitalizations:______________________________

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FAMILY HISTORY: (Include history of diabetes, heart disease, hypertension, colon, breast, ovarian cancer, other cancers, autoimmune diseases, and age at diagnosis if known)

Relative	Alive/Deceased	Age	Health Problems
Mother	____________	_____	______________________________
Father	____________	_____	______________________________
Sister	____________	_____	______________________________
Brother	____________	_____	______________________________
Child(ren)	____________	_____	______________________________

SOCIAL HISTORY:

Alcohol use: ☐ Yes ☐ No Number of drinks/frequency______________________

Drug use: ☐ None ☐ Marijuana ☐Other______________________

Caffeine use: ☐ None ☐ 1-3 servings/day ☐ 4-6/day ☐ >6/day Type______________

Tobacco use: ☐ Never ☐Currently smoke __________ pack(s) per day for ____________years

☐ Previously smoked ______ pack(s) per day for ________________ years

☐ Currently chew tobacco for ______________________years

☐ Previously chewed tobacco for _______ years. Quit______________

Marital status: ☐ Single ☐ Married ☐Partner ☐Widowed ☐Separated ☐Divorced

Children ☐ Yes ☐ No Ages______________________

Exercise: ☐ None Days per week______ Type______________

Occupation: ______________________________

ALLERGIES:

Medication/food/environmental/drug allergy	Reaction
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

PREVENTIVE SCREENING AND VACCINATIONS:

Last influenza vaccination____________________ Last pneumonia vaccination____________________

Last shingles vaccination____________________ Last tetanus vaccination________________________

Last colonoscopy__________________________ Last PSA/prostate exam________________________

Last Bone density test______________________ Last pap smear_______________________________

Last mammogram__________________________

OBSTETRIC/GYNECOLOGY HISTORY:

Number of pregnancies_____________________

Number of vaginal deliveries_________________ Number of cesarean sections_____________

Number of miscarriages_____________________ Number of abortions__________________________

Last menstrual period_______________________

Any pregnancy complications (i.e. gestational diabetes, pre-eclampsia)___________________________

____

History of sexually transmitted infection? ☐ Yes ☐ No Type/Year_____________________________

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MEDICATIONS, VITAMINS, AND SUPPLEMENTS:

Name	Strength/Number taken and frequency