Memorial INTERNAL MEDICINE

TO BE COMPLETED BY PATIENT (PLEASE PRINT)

Name _____

Date of Birth _____ Age _____
Height _____ Weight _____

Drug Allergies _____

Chief Complaints
(Please list in order of importance the present health problems you are experiencing)

1. _____
2. _____
3. _____

Hospitalizations/Surgeries

YEAR	ILLNESS/SURGERY	YEAR	ILLNESS/SURGERY

Past Medical History

Have you ever had the following? (circle yes or no)

Measles	yes	no	Migraines	yes	no
Mumps	yes	no	Tuberculosis	yes	no
Chickenpox	yes	no	Diabetes	yes	no
Whooping Cough	yes	no	Cancer	yes	no
Scarlet Fever	yes	no	Polio	yes	no
Diphtheria	yes	no	Glaucoma	yes	no
Pneumonia	yes	no	Hernia	yes	no
Smallpox	yes	no	Transfusions	yes	no
Rheumatic Fever	yes	no	Back Trouble	yes	no
Heart Disease	yes	no	Blood Pressure	yes	no
Arthritis	yes	no	Hemorrhoids	yes	no
Venereal Disease	yes	no	Asthma	yes	no
Anemia	yes	no	Bladder Infection	yes	no
Epilepsy	yes	no	Hives/Eczema	yes	no
AIDS or HIV	yes	no	Infectious Mono	yes	no
Bronchitis	yes	no	Mitral Valve	yes	no
Stroke	yes	no	Hepatitis	yes	no
Ulcer	yes	no	Kidney Disease	yes	no
Thyroid Disease	yes	no	Bleeding Tendency	yes	no

Other problems not listed _____

Family History

Has any blood relative had any of the following? (circle yes or no)

Disease:			Relationship:				Relationship:
Cancer	yes	no	_____	Stroke	yes	no	_____
Tuberculosis	yes	no	_____	Epilepsy	yes	no	_____
Diabetes	yes	no	_____	Allergies	yes	no	_____
Heart Disease	yes	no	_____	Anemia	yes	no	_____
High Blood Pressure	yes	no	_____	Bleeding Tendency	yes	no	_____

Current Medications

Please include OTC medications, herbal supplements, vitamins, etc.

MEDICATION	DOSE	TIMES DAILY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Social History

Tobacco	yes	no	ppd _____/ years _____
Alcohol	yes	no	daily _____
Caffeine	yes	no	cups/day _____
Illegal Drugs	yes	no	type _____

Examinations

The last time you had the following (list the year)

Flu Vaccine	_____	Tetanus Shot	_____
Hepatitis	_____	T.B. Test	_____
Pneumonia	_____	Rubella Vaccine	_____
Stool Test	_____	Rectal Exam	_____
Colonoscopy	_____	Eye Exam	_____
PSA	_____	Cholesterol	_____

FOR WOMEN ONLY

Age of onset first period _____

Date of last period _____

Birth Control _____

Pregnancies _____

Miscarriages _____

Abortions _____

Last Breast Exam _____
Normal? yes no

Mammogram _____
Normal? yes no

Pap/Pelvic Exam _____
Normal? yes no