Birmingham Internal Medicine Associates, PC

Medical History Form

Date: ________________________ **Who referred you?** ________________________________

Name:____ **Date of Birth:** _______________________

Race (circle one) :
*American Indian/Alaskan Native * Asian * Black/African American * Hawaiian/Pacific Islander
* White * Other * Unknown

Ethnicity: (circle one) * Hispanic/Latino *Not Hispanic/Latino * Unknown *Declined

Height: ___________ **Weight**: _______________ **Marital Status**: M S W D **Sex**: Male Female

Pharmacy Name: ____ **Phone#:**_____________________

Reason for today's visit: □ Routine physical □ Problem, please describe__________________________

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Please check if you had any of these medical problems in the past:					
ILLNESS	***YES***	***NO***	***ILLNESS***	***YES***	***NO***
Acid Reflux			Heart Disease		
Anemia			Hepatitis / Jaundice		
Anxiety			High Blood Pressure		
Arthritis / Joint Pain			High Cholesterol		
Asthma			Kidney Infections		
Back Pain			Kidney Stones		
Blood Transfusion			Migraines		
Bowel Trouble			Mood Disorders		
Breast Cancer			Osteoporosis		
Cancer			Pneumonia		
Chronic Lung Disease			Rheumatic Fever		
Depression			Sexually Transmitted Disease		
Diabetes			Stroke		
Fracture			Tuberculosis (TB)		
Glaucoma			Thyroid Disease		
Headaches			Ulcers		
Heart Murmur			OTHER:		

Please list your last test or immunization:			
TEST	***DATE***	***IMMUNIZATIONS***	***DATE***
Last PAP smear		Flu Vaccine	
Abnormal PAP smear		Pneumonia Vaccine	
Bone Density Test		Tetanus Vaccine	
Colonoscopy / Sigmoidoscopy		Hepatitis Vaccine	
Mammogram		Zostervax (Shingles) Vaccine	
PSA		TB skin test	

Name: ____________________________________ Date of Birth: __________________________

Please list any past injuries or illness:	
Date	***Type of Illness or Injury***

Please list all operations or hospitalizations you have had:	
Date	***Surgery or Reason for Hospitalization***

MEDICATIONS- please list ALL prescriptions, over the counter medications you are now taking; including vitamins and hormones		
Name	***Dosage***	***How Often***

Please list all allergies to medications, foods, latex, etc	
Allergy	***Reaction***

Name: ___________________________________ Date of Birth: _________________________

Family History							
ILLNESS	Yes	NO	Relative	ILLNESS	Yes	No	Relative
Anemia				Heart Trouble			
Arthritis				Hepatitis/Jaundice			
Asthma				High Blood Pressure			
Bowel issues/ulcers				High Cholesterol			
Cancer Type:				Kidney Infections/ Kidney Stones			
Chronic Lung Disease				Stroke			
Depression/Anxiety				Thyroid Disease			
Diabetes				Tuberculosis			
Glaucoma				HIV/AIDS			
				other			

FEMALE PATIENTS ONLY	
Do you use birth control? □ yes type: ______ □ no	Date of last period
What age did you have your first period?________	
How many days are there from the start of a period to the star of the next period? ________________ days	
Flow: □ Light □ Medium □Heavy	How long does your period usually last? ______days
Are you on Hormone Replacement Therapy (hormones)? □ Yes □ No	
Have you gone through Menopause? □ Yes □ No At what age?	

SOCIAL HISTORY	
Occupation:	
Do you exercise? □ None □ Less than 3 times per week □ More than 3 times per week	
Do you smoke? □ Yes □ No	*Packs per day:* *Number of years smoking:* *Quit years:*
Do you drink alcohol? □ Yes □ No	*Drinks per day:* *Drinks per week:*
Do you use drugs? □ Yes □ No	*Kind of drug:* *Frequency:*
History of Abuse? □ Yes □ No	*Type:* □ *Physical* □ *Emotional* □*Sexual*
Are you sexually active? □ Yes □ No With your spouse? □ □ With men? □ □ With women? □ □ With both? □ □	

Name: ___________________________________ Date of Birth: _________________________

CONSTITUTIONAL		**GASTROINTESTINAL**		**NEUROLOGIC**	
Weight Loss		Constipation		Memory difficulties	
Weight Gain		Abdominal Pain		Speech difficulties	
Fever		Blood in Stool		Seizures	
Fatigue		Hemorrhoids		Loss of balance	
Night Sweats		Jaundice		**MUSCULOSKELETAL**	
Hot flashes		Heartburn		Joint pain or swelling	
EYES		Indigestion		Muscle pain	
Double Vision		Nausea		Back pain	
Vision Changes		Vomiting		Neck pain	
HEENT		Diarrhea		**ENDOCRINE**	
Congestion		**GENITOURINARY**		Loss of hair	
Drainage		Urgency of urination		Difficulty tolerating cold	
Sore Throat		Frequency		Excessive thirst	
Hearing Loss		Painful urination		**PSYCHIATRIC**	
Ringing in Ears		Losing urine		Anxiety	
Nose Bleeding		Nighttime urination		Depression	
Thyroid Mass		Blood in urine		Impulsive behavior	
BREAST		Decreased sex drive		Suicidal thoughts	
Lumps		Painful intercourse		Excessive anger	
Tenderness		Possible pregnancy		Mood swings	
Swelling		Genital sores		Emotional abuse	
Discharge		Discharge from penis		Physical abuse	
Pain in Breast		Vaginal discharge		Sexual abuse	
Changes in Breast		Vaginal bleeding		Sleep disturbance	
CARDIOVASCULAR		**SKIN**		Hematologic/Lymphatic	
Chest Pain		Rashes		Bruises, frequently/easy	
Irregular Heart Beats		Itching		Cuts do not stop bleeding	
Rapid Heart Beats		Skin dryness		Enlarged lymph nodes	
Fainting		Skin lesions		**ALLERGIC/IMMUNOLOGIC**	
Swelling of Legs		Changes to lesions or moles		Frequent illness	
Varicose Veins		Acne		Seasonal allergies	
RESPIRATORY		Neurologic		Other:	
Wheezing		Headaches		1.	
Cough		Dizziness		2.	
Shortness of breath		Muscular weakness		3.	
Spitting up blood		Numbness/tingling		4.	
Excessive snoring		Difficulty concentrating		5.	