INTERNAL MEDICINE ASSOCIATES OF IRVING
HEALTH HISTORY

Name _____ **Today's Date**_____
Age_____ **Birthdate**_____ **Date of last physical examination**_____

In order to obtain a comprehensive evaluation of your health, your doctor asks that you carefully complete this questionnaire. This form is intended to supplement your interview and is entirely confidential. Thank you.

Occupation: _____
Drug Allergies & Reactions: _____
_____
Medications (include vitamins, over-the-counter meds, oral contraceptives)**:**_____
_____
_____
_____

Social Habits: Check and describe all that apply.
____Caffeine_____ ____Tobacco_____
____Alcohol_____ ____Drugs_____
____Exercise_____ ____Diet_____
____Sexually Active_____

Women: Date of last period_____ Menstrual History_____
# of pregnancies _____ Contraceptive Method_____
Any problems? _____

Medical Illnesses (e.g. diabetes, cancer, lung/heart/stomach/kidney/liver disease, nervous or psychiatric disorders):_____
_____
_____

Surgeries/Hospitalization (e.g. appendix, tonsils, hysterectomy, vasectomy, etc.):
_____
_____
_____

Family History:

	Living?	Age/age at Death	Describe any health problem/cause of death
Father			
Mother			
Brothers/Sisters			

Please list any "family" illnesses_____

Health Maintenance: Please indicate the year you last had the following:

TB Skin Test_____Pap Smear_____
Eye Exam_____ Bone Density_____
Sig/Colonoscopy_____ Cholesterol_____
Mammogram_____ PSA_____
Dental Exam_____

Immunizations:
Tetanus_____ Pneumonax_____
Influenza_____ Hepatitus A/B_____
Other_____

Please check Symptoms you currently have or suffer from on a chronic basis:

Name _____ Date _____

X GENERAL
___Chills/Sweats _
___Depression _
___Dizziness
___Fainting __
___Fever __
___Forgetfulness/Poor Memory
___Headache __
___Difficulty Sleeping _
___Loss/Gain of weight __
___Nervousness/Anxiety
___Fatigue _
___Poor Concentration __
___Temperature intolerance

X MUSCLE/JOINT/BONE __
Pain, weakness, numbness in:
___Arms/Hands _
___Legs/Feet __
___Back/Hips __
___Neck/Shoulders
_

X SKIN __
___Bruise easily
___Hives
___Itching/dryness
___Changes in moles
___Rash __
___Sore that won't heal
___Nail changes _

X EYE,EAR,NOSE,THROAT
___Vision disturbances
___Difficulty swallowing
___Earache __
___Ear drainage __
___Hay fever/allergies
___Hoarseness _
___Loss of hearing
___Nosebleeds
___Sinus problems
___Dental problems
___Bleeding gums

X GASTROINTESTINAL
__Poor appetite _
__Bloating _
___Bowel changes
_Constipation __
_Diarrhea __
___Excessive gas __
_Excessive thirst __
__Hemorrhoids _
_Indigestion
___Nausea/Vomiting
__Black/Bloody Stools _
_Stomach pain __
__

X CARDIOVASCULAR __
_Chest pain/discomfort
___High Blood Pressure
__Irregular Heart Beat
_Palpitations __
_Poor circulation __
___Swelling of ankles
__Varicose veins _
_Exercise intolerance __

X PULMONARY
___Persistent cough
___Cough up blood
_Shortness of breath
___Wheezing
__Night Sweats

X GENITO-URINARY
___Blood in urine
___Frequent urination
_Lack of bladder control
_Painful urination
___Frequent infection
__Kidney stone

X MEN ONLY
__Breast lump
__Erection difficulties
___Problems with sex life
_Lump in testicles
_Penis discharge
_Sore on penis
_Urinary dribbling
__Weak urinary flow

X WOMEN ONLY
__Abnormal pap smear
_Bleeding between periods
_Breast lump
_Breast pain
___Menstrual pain
___Hot flashes
___Nipple discharge
_Painful intercourse
_Problems with sex life
___Vaginal discharge
__Vaginal itching
_Premenstrual symptoms

X OTHER