

HC HIGHLAND CLINIC

INTERNAL MEDICINE
PATIENT HISTORY FORM
 Fax to 4451

Name: _____ DOB: _____ Age: _____

Reason for Visit: _____

Allergies: _____

Medications: *Drug Name Dose/Strength How you take it (for example, once a day, twice a day, etc)*

Review of Systems: Do you have?

- | | | | |
|--------------------------------------|--|--|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Reflux | <input type="checkbox"/> Bruising |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Skin Lesion | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Chronic Headache | <input type="checkbox"/> Seizures | <input type="checkbox"/> Frequent Urination |
| | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression | <input type="checkbox"/> Asthma |

Past Medical History:

Do you have?

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Other _____ | |

Past Surgical History:

Have you had?

- | |
|--|
| <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> _____ |
| <input type="checkbox"/> None |

Family History:

- | | | | |
|--|-------------------------------|---|------------|
| <input type="checkbox"/> High Blood Pressure | Who: _____ | <input type="checkbox"/> Cancer | Who: _____ |
| <input type="checkbox"/> Heart Disease | Who: _____ | <input type="checkbox"/> Depression | Who: _____ |
| <input type="checkbox"/> Diabetes | Who: _____ | <input type="checkbox"/> Kidney Disease | Who: _____ |
| <input type="checkbox"/> Osteoporosis | Who: _____ | | |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> None | | |

Social History:

Occupation: _____

Tobacco Use current former never

Type _____ amt/day

Alcohol Use Yes No

Drugs _____

Transfusions Yes No

Married Divorced Widowed

Health Maintenance:

	Date of last		Date of last
Last Pap/Pelvic	_____	Eye Exam	_____
Mammogram	_____	Tetanus	_____
Rectal	_____	Flu	_____
Pneumovax	_____	Other	_____
PSA	_____		
Colonoscopy	_____		