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| {{BARCODELEFTRIGHT}} |
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| **INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE** |

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| Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. |

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| Main reason for today's visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **ALLERGIES** |

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| **List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.** |

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| ALLERGY |
| 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| REACTION |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **FAVORITE PHARMACY** |

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| **MEDICATIONS** |

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| **Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.** |

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| DRUG NAME |
| 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 9.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 10.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| STRENGTH |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| FREQUENCY TAKEN |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **IMMUNIZATION HISTORY** |

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| **Immunizations and most recent date:** |
|    Chickenpox | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|    Flu Shot | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|    Gardasil/HPV | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|    Hepatitis A | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|    Hepatitis B | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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|    Meningococcus | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|    MMR *(Measles, Mumps, Rubella)* | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|    Pneumonia | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|    Tdap *(Tetanus and pertussis)* | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|    Tetanus | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|    Zostavax *(Shingles)* | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY** |

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| Last PAP Smear       Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      Abnormal |
| Last Mammogram       Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      Abnormal |
| Age of first menstrual period: \_\_\_\_\_\_\_\_ |
| Date of last menstrual period or age of menopause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Number of pregnancies: \_\_\_\_\_\_       births: \_\_\_\_\_\_\_ |
| miscarriages: \_\_\_\_\_\_       abortions: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|    Cesarean sections       If yes, then number: \_\_\_\_\_\_ |

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|    Bleeding between periods |
|    Heavy periods |
|    Extreme menstrual pain |
|    Vaginal itching, burning, or discharge |
|    Wake in the night to go to the bathroom |
|    Hot flashes |
|    Breast lump or nipple discharge |
|    Painful intercourse |
|    Sexually active |
|         Current sexual partner is      Female      Male        Do you use condoms      Yes      No        Other Birth control method used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_           Interested in being screened for STD's |

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| **PAST MEDICAL HISTORY** |

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| **Please check all that apply:** |

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|    Anxiety Disorder |
|    Arthritis |
|    Asthma |
|    Bleeding Disorder |
|    Blood Clots (or DVT) |
|    Cancer |
|    Coronary Artery Disease |
|    Claustrophobic |
|    Diabetes - Insulin |
|    Diabetes - Non-Insulin |
|    Dialysis |

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|    Diverticulitis |
|    Fibromyalgia |
|    Gout |
|    Has Pacemaker |
|    Heart Attack |
|    Heart Murmur |
|    Hiatal Hernia or Reflux Disease |
|    HIV or AIDS |
|    High Cholesterol |
|    High Blood Pressure |
|    Overactive Thyroid |

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|    Kidney Disease |
|    Kidney Stones |
|    Leg/Foot Ulcers |
|    Liver Disease |
|    Osteoporosis |
|    Polio |
|    Pulmonary Embolism |
|    Reflux or Ulcers |
|    Stroke |
|    Tuberculosis |
|    Other |

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| **PAST SURGICAL HISTORY** |

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| **SURGERY** |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **REASON** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **YEAR** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **HOSPITAL** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **FAMILY HEALTH HISTORY** |

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| **RELATION** | **ALIVE?** | **AGE** | **SIGNIFICANT HEALTH PROBLEMS** |
| **Grandmother** (maternal) | Y/N | \_\_\_\_\_\_ |    Alcoholism      Arthritis      Depression      Cancer      Diabetes      Genetic disease |
|   |   |   |    Heart disease        Hypertension        Osteoporosis        Stroke |
| **Grandfather** (maternal) | Y/N | \_\_\_\_\_\_ |    Alcoholism      Arthritis      Depression      Cancer      Diabetes      Genetic disease |
|   |   |   |    Heart disease        Hypertension        Osteoporosis        Stroke |
| **Grandmother** (paternal) | Y/N | \_\_\_\_\_\_ |    Alcoholism      Arthritis      Depression      Cancer      Diabetes      Genetic disease |
|   |   |   |    Heart disease        Hypertension        Osteoporosis        Stroke |
| **Grandfather** (paternal) | Y/N | \_\_\_\_\_\_ |    Alcoholism      Arthritis      Depression      Cancer      Diabetes      Genetic disease |
|   |   |   |    Heart disease        Hypertension        Osteoporosis        Stroke |
| **Father** | Y/N | \_\_\_\_\_\_ |    Alcoholism      Arthritis      Depression      Cancer      Diabetes      Genetic disease |
|   |   |   |    Heart disease        Hypertension        Osteoporosis        Stroke |
| **Mother** | Y/N | \_\_\_\_\_\_ |    Alcoholism      Arthritis      Depression      Cancer      Diabetes      Genetic disease |
|   |   |   |    Heart disease        Hypertension        Osteoporosis        Stroke |
| **Brother/Sister** | Y/N | \_\_\_\_\_\_ |    Alcoholism      Arthritis      Depression      Cancer      Diabetes      Genetic disease |
|   |   |   |    Heart disease        Hypertension        Osteoporosis        Stroke |
| **Brother/Sister** | Y/N | \_\_\_\_\_\_ |    Alcoholism      Arthritis      Depression      Cancer      Diabetes      Genetic disease |
|   |   |   |    Heart disease        Hypertension        Osteoporosis        Stroke |
| **Other:\_\_\_\_\_\_** | Y/N | \_\_\_\_\_\_ |    Alcoholism      Arthritis      Depression      Cancer      Diabetes      Genetic disease |
|   |   |   |    Heart disease        Hypertension        Osteoporosis        Stroke |

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| **SOCIAL HISTORY** |

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| **Education**        Less than 8th grade   High school   2 year college        4 year college   Post graduate |

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| **Marital Status**        Married        Single   Divorced        Separated        Widowed   Domestic partner |

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| **Exercise Level** |    None (No exercise)   Occasional exercise   Moderate exercise   High level exercise |
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| **Caffeine** |    None |   Occasional |
|  |    Moderate |    Heavy |
|   | # of cups/cans per day? \_\_\_\_ |

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|  |
| **Alcohol** | Do you drink alcohol? |
|    Yes        No |
| If so, how often? |

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|  |    Occasionally        < 3 times a week   > 3 times a week |

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|   | How many drinks per week? \_\_ |
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| **Tobacco** | Do you use tobacco? |
|   |    Yes        No |

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|   | If not currently, did you ever use tobacco?      Yes      No   Cigarettes -\_\_\_\_pks./day   Chew - \_\_\_\_/day   Cigars - \_\_\_\_\_/day   # of years\_\_\_\_Or year quit \_\_\_\_\_\_\_\_\_\_ |

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| **Drugs** | Do you currently use recreational or street drugs?      Yes        No |
|   | If yes, list: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **REVIEW OF SYSTEMS** |

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| **Please check all that apply:** |
| **Allergic/Immunologic** |
|  | Frequent Sneezing |
|  | Hives |
|  | Itching |
|  | Runny Nose |
|  | Sinus Pressure |
| **Cardiovascular** |
|  | Arm Pain on Exertion |
|  | Chest Pain on Exertion |
|  | Chest Heaviness/Pressure on Exertion |
|  | Irregular Heart Beats (Palpitations) |
|  | Known Heart Murmur |
|  | Light-headed on Standing |
|  | Shortness of Breath When Lying Down |
|  | Shortness of Breath When Walking |
|  | Swelling (edema) |
| **Constitutional** |
|  | Exercise Intolerance |
|  | Fatigue |
|  | Fever |
|  | Weight Gain (\_\_\_\_lbs) |
|  | Weight Loss (\_\_\_\_lbs) |
| **Eyes** |
|  | Dry Eyes |
|  | Irritation |
|  | Vision Change |
| Date of Last Exam:\_\_\_\_\_\_\_\_\_ |

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| **Ears/Nose/Mouth/Throat** |
|  | Bleeding Gums |
|  | Difficulty Hearing |
|  | Dizziness |
|  | Dry Mouth |
|  | Ear Pain |
|  | Frequent Infections |
|  | Frequent Nosebleeds |
|  | Hoarseness |
|  | Mouth Breathing |
|  | Mouth Ulcers |
|  | Nose/Sinus Problems |
|  | Ringing in Ears |
| **Endocrine** |
|  | Fatigue |
|  | Increased |
|   | Thirst/Hunger/Urination |
| **Gastrointestinal** |
|  | Abdominal Pain |
|  | Black or Tarry Stool |
|  | Blood in Stool |
|  | Change in Appetite |
|  | Frequent Indigestion |
|  | Hemorrhoids |
|  | Trouble Swallowing |
|  | Vomiting |
|  | Vomiting Blood |

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| **Genitourinary** |
|  | Blood in Urine |
|  | Difficulty Urinating |
|  | Incomplete Emptying |
|  | Increased Urinary Frequency |
|  | Urinary Loss of Control |
| **Hematologic/Lymphatic** |
|  | Easy Bruising/Bleeding |
|  | Swollen Glands |
| **Integumentary (Skin)** |
|  | Changes in Moles |
|  | Dry Skin |
|  | Eczema |
|  | Growth/Lesions |
|  | Itching |
|  | Jaundice (Yellow Skin/Eyes) |
|  | Rash |
| **Musculoskeletal** |
|  | Back Pain |
|  | Joint Pain |
|  | Muscle Aches |
|  | Muscle Weakness |

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| **Neurological** |
|  | Dizziness |
|  | Fainting |
|  | Headaches |
|  | Memory Loss |
|  | Migraines |
|  | Numbness |
|  | Restless Legs |
|  | Seizures |
|  | Weakness |
| **Psychiatric** |
|  | Alcohol Overuse |
|  | Anxiety/Stress |
|  | Depression |
|  | Do Not Feel Safe in Relationship |
|  | Mania |
|  | Sleep Problems |
| **Respiratory** |
|  | Cough |
|  | Coughing Up Blood |
|  | Shortness of Breath |
|  | Sleep Apnea |
|  | Snoring |
|  | Wheezing |

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| Please add any other information about your health that you would like your provider to know here: |

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