EASTSIDE INTERNAL MEDICINE
PATIENT HISTORY FORM

DATE: _____ **NAME:** _____ **DOB:** _____

Note: This is a confidential record and will be kept in your medical file.
Please check the appropriate box(s) and give explanation if asked.

Please check if you have had any of the following and indicate the <u>month & year</u> when last performed:

Vaccines:
- ☐ Influenza _____
- ☐ Hepatitis B _____
- ☐ Pneumonia _____
- ☐ Tetanus _____
- ☐ TB Skin Test _____
- ☐ Chicken Pox/Shingles _____

Tests:
- ☐ bone density _____
- ☐ chest x-ray _____
- ☐ colonoscopy _____
- ☐ stress test _____
- ☐ CT/MRI (type?) _____

Females only:
- ☐ GYN exam _____
- ☐ PAP test _____
- ☐ mammogram _____

Males only:
- ☐ prostate exam _____
- ☐ PSA test _____

Hospitalizations/Surgeries/Procedures ☐ None

What/Why	*When (year)*	*What/Why*	*When (year)*

Specialist visits *(ie: cardiologist, chiropractor, dentist, eye dr., foot dr., OB/GYN, etc)*

Physician Name	*Speciality*	*Date of last visit*

Allergies to medications ☐ None Known

Drug	*Reaction*	*Drug*	*Reaction*

Prescription medicines: ☐ None

Name of drug	*dose (mg)*	*# times/day*	*Name of drug*	*dose (mg)*	*# times/day*

OTC medicines ☐ None *(pain relievers, diet pills, antacids, laxatives, vitamins, herbals, etc)*

over

FAMILY HISTORY

Father: ☐ Living ☐ Deceased: At Age: _____ Cause of Death: _____

Mother: ☐ Living ☐ Deceased: At Age: _____ Cause of Death: _____

Children: # Living Sons:_____ Ages:_____ # Living Daughters: _____ Ages:_____
Any Deceased?_____ Cause:_____ Age:_____

Siblings: # Living Brothers: _____ # Deceased: _____ Causes:_____
Living Sisters: _____ # Deceased: _____ Causes:_____

Check all that apply: Y=yourself M=Mother F=Father D/S=Daughter/Son S/B=Sister/Brother GP=Grandparent

	Y	M/F	D/S	S/B	GP		Y	M/F	D/S	S/B	GP
Bleeding disorder						High cholesterol					
Cancer:						Kidney problems					
Diabetes						Lung disease					
Eating disorder						Mental illness					
Gastrointestinal						Seizures					
Genetic disorders						Sex. Trans. Disease					
Heart disease						Stroke/TIA					
High blood pressure						Other:					

SOCIAL HISTORY

Occupation: _____ **Education** (Highest grade completed in school):_____

Caffeine use: ☐ none ☐ Yes # cups a day/week/month?_____

Nutrition/ Exercise: Are you generally satisfied with your weight? ☐ Yes ☐ No
Would you like some information about nutrition counseling? ☐ Yes ☐ No
Do you exercise regularly? ☐ Yes ☐ No How often per week?_____
What kind of exercise?_____ How long (minutes)?_____

Safety: Do you wear a: sunscreen?☐ Yes ☐ No Do you feel safe in your home? ☐Yes ☐ No
Do you have excessive exposure at home/work to: ☐ Yes ☐ No (*check any/all that apply)*
☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne particles ☐ Noise
Are you a victim of abuse? ☐ Yes ☐ No If yes, which? ☐ Physical ☐ Emotional ☐ Sexual

Tobacco Use: ☐ never ☐ former, quit date:_____ ☐ current, Are you ready to quit? ☐ Yes ☐ No
How soon after awakening in the morning do you smoke? # of Mins: _____ # of Hrs:_____
Do you smoke every day? _____ How many cigarettes/day _____

Alcohol use: ☐ none ☐ Yes How often in the past year?_____ How many drinks each time? _____

Drug use: Have you ever used any recreational drugs (ex: marijuana, cocaine, heroin, intravenous drugs)? ☐ Yes ☐ No

Depression: Do you have little interest or pleasure in doing things? ☐ Yes ☐ No
Are you currently feeling down, depressed, or hopeless? ☐ Yes ☐ No

Patient Signature:_____ Date:_____

☐ *Updated* ☐ *No Changes* *Patient Signature:_____ Date:_____*

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☐ *Updated* ☐ *No Changes* *Patient Signature:_____ Date:_____*

☐ *Updated* ☐ *No Changes* *Patient Signature:_____ Date:_____*