Plano Internal Medicine Associates, PA

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PATIENT MEDICAL HISTORY

Name: _____ **Age:** _____ **Occupation:** _____

Chief Complaint: _____

VITALS **Weight:** _____ **Height:** _____ **Blood Pressure:** _____/ _____ **Temp:** _____

FAMILY HISTORY

Has any relative had:	Cancer of breasts, female organs, colon, melanoma	Yes	No
	Tuberculosis in the last 5 years	Yes	No
	Diabetes	Yes	No
	High blood pressure	Yes	No
	Kidney trouble (other than kidney stones)	Yes	No
	Heart Disease	Yes	No
	Anethesia complication	Yes	No

Exercise: Do you exercise at least 20 minutes, 3 times a week? Yes No

Alcoholic Beverages: _____ Never _____ Occassionally _____Moderately _____ Daily

Smoking: Do you smoke? Yes No

If yes, how many packs per day? _____

If you quit, how long has it been? _____

Drug Use: Have you used, previously used, or had problems with any of the following:

_____ Marijuana _____ Heroin _____ Cocaine _____ Other Recreational Drug :_____

MEDICAL HISTORY Have you ever had any of the following:

Asthma or breathing problems	Yes	No	Colon trouble or bowel disorder	Yes	No
Anemia (longer than 3 months)	Yes	No	Kidney trouble	Yes	No
Tuberculosis	Yes	No	Venereal disease	Yes	No
High Blood Pressure	Yes	No	Varicose veins or Phlebitis	Yes	No
Heart Disease or murmur	Yes	No	Bleeding disorders	Yes	No
Diabetes	Yes	No	Seizures, loss of consciousness	Yes	No
Depression	Yes	No	Visual disturbance	Yes	No
Thyroid disorder	Yes	No	Treatment for nervous disorder	Yes	No
Ulcer or stomach problems	Yes	No	Cancer	Yes	No
Hepatitis, jaundice	Yes	No	Blood transfusions	Yes	No
Hospitalization for psychiatric reasons	Yes	No	Alchol abuse	Yes	No
Other _____			Drug Abuse	Yes	No

Please explain "Yes" Answers: _____

_____

IMMUNIZATIONS and OTHER

Have you had a tetanus shot in the last 10 years? Yes, Date _____ No

(Only age 50 and over) Have you had a pneumonia shot in the last 10 years? Yes, Date _____ No

Have you had any other immunization in the past? _____

Last Dental Exam: _____ Dentist Name: _____

Last Eye Exam: _____ Eye Dr Name: _____

SURGERIES (*Please include Dates)*

_____

DRUG ALLERGIES: _____

MEDICATIONS: ***Please list all medications you are currently taking including dosage***

_____

_____

_____

Patient Signature:_____ **Date:** _____