PIEDMONT
INTERNAL
MEDICINE

Piedmont Internal Medicine-Medical History Form

Name: _____Date of Birth: _____

List main reason for today visit_____

_____

List any other active problems (include treating physician If applicable) _____

_____

_____

Allergies and reaction_____

Medications and dosages (include supplements) _____

_____

_____

Past medical illnesses (Please put a check by all that applies)

__Alcohol/Drug Abuse	__Cancer	__Heart murmur	__STD(type)
__Anemia	__Crohn's disease	__Hepatitis B/C	__Sickle cell disease
__Aneurysm	__COPD/Emphysema	__High cholesterol	__Sleep apnea
__Anxiety disorder	__Depression	__HIV	__Stomach ulcer
__Arthritis	__Diabetes	__Hypertension	__Stroke
__Asthma	__Glaucoma	__Kidney disease	__Thyroid disease
__Blood disorder	__Gout	__Kidney stones	__Tuberculosis
__Blood clot	__Hay fever	__Liver disease	__Positive TB skin test
__Blood transfusion	__Heart disease	__Seizure	__Ulcerative colitis

Past operations/Procedures and/or Hospitalizations (include date) _____

_____

_____

_____

Family history (Indicate major medical problems, or if deceased the cause)

Maternal Grandmother_____
Maternal Grandfather_____
Paternal Grandmother_____
Paternal Grandfather_____
Mother_____

Father_____
Siblings_____
Children_____

Social History

Occupation: _____ Marital Status: _____ Children: _____
Alcohol: _____ How often: _____ Quantity: _____
Tobacco: _____Pack per day: _____ How many Years: _____
Former Smoker: _____ Pack per day: _____ Year quit: _____
Other Tobacco/Nicotine: _____ Type: _____Quantity: _____
Illegal Drugs: _____
Exposure to asbestos or other hazardous material: _____
Do you have a living will? _____
Healthcare proxy: _____ If so Name: _____Relationship: _____

Health Maintenance

Last Menstrual cycle: _____ Last pap smear: _____
Last mammogram: _____ Last Colonoscopy: _____
Last Prostate cancer screening: _____ Last bone density: _____

Immunizations:

Pneumonia: _____ Flu: _____ Tetanus/TD/Tdap: _____
Hepatitis A: _____Hepatitis B: _____

Review of Systems: (Please put a check by all that applies)

__Weight gain
__Persistent cough
__Blood in stool
__Headache
__Weight loss
__Fever
__Chest Discomfort
__Difficult urinating
__Memory Loss
__Night Sweats
__Breast Lump
__Leg pain
__Dizziness
__Palpitations
__Trouble breathing
__Numbness/Tingling
__Weakness
__Fainting
__Frequent urination
__Tremor
__Fatigue
__Exercise intolerance
__Penis Discharge
__Breast pain
__Leg swelling
__Pain with intercourse
__Insomnia
__Mood Swings
__Difficulty swallowing
__Vaginal discharge/bleeding
__Nausea
__Change in vision
__Anxiety
__Depression
__Change in hearing
__Heartburn
__Skin rash
__Feeling hot
__Nipple discharge
__Runny nose
__Nose bleed
__Vomiting
__Blood in sputum
__Blood in vomit
__Short of breath
__Constipation
__Diarrhea
__Change in bowels
__Back pain
__feeling cold

Signature: _____Date: _____

Reason patient is unable to sign: _____ Date: _____