WASHINGTON COUNTY INTERNAL MEDICINE, P.C.

Health History

FULL NAME_____ Birthdate_____ Today's Date_____ Office Use (MRN)_____

Highest Level of Education ___ High School ___ College ___ Graduate Level Type of work (Past and Present) _____

List any allergies_____

List any medications you take, including over the counter

NAME	DOSE	HOW OFTEN TAKEN		NAME	DOSE	HOW OFTEN TAKEN

Have you ever been diagnosed with any of the following?

	YES	NO			YES	NO			YES	NO
Diabetes				Asthma				Arthritis		
Hypertension				Emphysema/ COPD				Osteoporosis		
Heart Disease				Heart Burn/ GERD				Gout		
Heart Murmur				Hepatitis				Kidney Disease		
Peripheral Artery Disease				Diverticulosis				Glaucoma		
Rheumatic Fever				Anemia				Restless Leg Syndrome		
Stroke				Bleeding Disorders				Peripheral Neuropathy		
High Cholesterol				Cancer				Mental Health Problems		
Sleep Apnea				Thyroid problems				Other Health Problems		

List any surgeries you have had

Type	Date	Doctor's Name		Type	Date	Doctor's Name

Health Habits

Tobacco	Yes	No	Past	Daily Amount	Years of Use	When Stopped		Alcohol	Yes	No	Past	Daily Amount	Years of Use	When Stopped
Smoke								Beer						
Dip								Wine						
Chew								Liquor						
Drugs														

If you answered yes to Drug use:

Type of Drugs_____ Have you ever misused prescription drugs? ____Yes ____No

When was your last

Screenings	Date	Screenings	Date	Vaccines	Date	Vaccines	Date	Vaccines	Date
Pap Smear		Colonoscopy		Flu		Pneumonia (PVC 13)		Meningococcal	
Mammogram		Prostate Exam		Hepatitis		Pneumonia (PPSV 23)		COVID 19 #1	
Bone Density		Eye Exam		Tetanus		Measles/Mumps/Rubella		COVID 19 #2	
				HPV		Shingles		Other	

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Has anyone in your family been diagnosed with

	Yes	No	Parent	Grandparent	Sibling	Children
Heart Disease						
Hypertension						
Stroke						
Cancer						
Diabetes						
Thyroid						
Osteoporosis						
Mental Illness						

Within the last 3 months, have you ever been bothered with

Sinus Problems	Yes	No		Yes	No		Yes	No
Voice change			Jaundice			Anxiety		
Chronic sore throat			Loss of appetite			Frequent urination		
Swollen glands			Nausea / Vomiting			Painful urination		
Frequent cough			Constipation			Blood in urine		
Asthma / Wheezing			Diarrhea			Incontinence		
Shortness of breath			Blood in stool			Sexual difficulty		
Coughing blood			Stomach pain			Numbness or tingling in arms		
Chest pain			Indigestion / Reflux			Numbness or tingling in legs		
Heart skipping			Weight loss / gain			Seizures		
Heart racing			Problems sleeping			Vision changes		
Swelling			Loud snoring			Hearing loss		
Fainting			Frequent leg movements at night			Easy bruising or bleeding		
Dizziness			Muscle weakness			Anemia		
Fatigue			Joint pain			Any transfusions in the past		
Excessive Thirst			Neck / Back pain			Change in periods		
Dry Skin			Muscle spasms			Painful periods		
Changes in moles			Nervousness			Abnormal vaginal bleeding		
Rashes			Depression					

Do you exercise regularly? Yes _____ No _____ Type of exercise _____ How often _____

Are there any other health concerns you have at this time: _____

_____

Patient's Signature: _____ Date: _____

Office Notes:

Provider's Signature: _____ Date: _____