INTERNAL MEDICINE **PATIENT QUESTIONNAIRE & EXAM** DATE:

NAME | DATE OF BIRTH

OCCUPATION/ EMPLOYER | HIGHEST LEVEL OF EDUCATION

REASON FOR VISIT: _____

HOSPITALIZATIONS ↓ IF YOU HAVE BEEN IN HOSPITAL OVERNIGHT, STATE THE YEAR OF ILLNESS/OPERATION (EXCEPT NORMAL PREGNANCIES)

YEAR	ILLNESS / OPERATION	YEAR	ILLNESS / OPERATION

PAST MEDICAL FAMILY HISTORY PLEASE CHECK IF YOU (PERS.) OR ANY BLOOD RELATIVE (RELATION) HAD ANY OF THE FOLLOWING CONDITIONS.

	PERS.	RELATION	EXPLANATION		PERS.	RELATION
1) RECENT WEIGHT LOSS				17) KIDNEY / BLADDER		
2) MIGRAINE HEADACHES				18) NEUROLOGICAL		
3) EPILEPSY / CONVULSIONS				19) ARTHRITIS		
4) EYE DISEASE *(OTHER THAN GLASSES)*				20) OSTEOPOROSIS		
5) HEARING DISORDER				21) CANCER - *TYPE*		
6) RECURRENT NOSE BLEEDS						
SINUS / THROAT INFECTIONS						
7) ANGINA - CHEST PAIN						
8) HEART ATTACK						
9) HIGH BLOOD PRESSURE				22) BLEEDING DISORDER		
10) STROKE				23) BLOOD TRANSFUSIONS		
11) HIGH CHOLESTEROL				24) ANEMIA		
12) HEART VALVE DISORDER				25) DIABETES		
13) LUNG DISEASE				26) ALCOHOLISM		
14) STOMACH ULCER				27) MENTAL ILLNESS		
15) BOWEL PROBLEMS				28) DEPRESSION		
16) LIVER / HEPATITIS						

LIST ALL MEDICATIONS YOU NOW TAKE:

MEDICATION	DOSE	TIMES/DAY

DO YOU NOW OR HAVE YOU EVER:

SMOKED CIGARETTES [Y] [N] Pk/Day: ____ # Yrs.: ____

DRANK ALCOHOL [Y] [N] Drinks/Wk: _____

DRANK COFFEE/TEA [Y] [N] Cups/Day: _____

USED STREET OR ILLEGAL DRUGS [Y] [N]

TYPE _____

THE LAST TIME YOU HAD A - (YEAR)

FLU VACCINE _____ TETANUS SHOT _____

HEPATITIS VACC. _____ PNEUMONIA SHOT _____

T.B. TEST _____ RECTAL EXAM _____

STOOL BLD. TEST _____ SIGMOID EXAM _____

EYE EXAM _____ DENTAL EXAM _____

CHOLEST. TEST _____ RESULT _____

DRUG ALLERGIES:

DRUG	REACTION

FOR WOMEN ONLY:

DATE OF LAST MENST. PERIOD _____

DO YOU USE BIRTH CONTROL? [Y] [N]

TYPE _____

NUMBER OF PREGNANCIES _____

NUMBER OF LIVE BIRTHS _____

NUMBER OF ABORTIONS _____

NUMBER OF MISCARRIAGES _____

YEAR OF LAST: _____

PAP TEST ☐ NORMAL ☐ ABNORMAL

BREAST EXAM ☐ NORMAL ☐ ABNORMAL

MAMMOGRAM ☐ NORMAL ☐ ABNORMAL

ARE YOU HAVING ANY SYMPTOMS OR PROBLEMS THAT YOU WOULD LIKE TO DISCUSS? *PLEASE LIST THEM.*

DO YOU HAVE ANY OTHER MEDICAL PROBLEMS FOR WHICH YOU HAVE BEEN SEEING A DOCTOR ON A REGULAR BASIS? *PLEASE LIST THEM.*

MEDICAL HISTORY ADDITIONAL NOTES

PHYSICAL EXAM

VITAL SIGNS	HT.	WT.	BP SUPINE	BP SITTING	PULSE	RESP. RATE	TEMP.

GENERAL APPEARANCE:

EXAMINATION

	NORM.	ABNORM.
1) HEAD/SCALP		
2) EYES		
A) FUNDI		
3) EARS		
4) NOSE/THROAT		
5) NECK		
A) THYROID		
6) HEART		
7) LUNGS		
8) ABDOMEN		
9) RECTAL		
A) PROSTATE		
10) EXTREMITIES		
A) PULSES		
11) NEUROLOGICAL		
A) DTR		
12) JOINTS		
13) GENITALIA		
14) BREASTS		

LAB TESTS URINALYSIS - COLOR S. GR. pH PROT GLUC KETO BILI BLOOD NITRITE UROB MICRO -

						OTHER TESTS / COMMENTS
HgB		HDL -		LDL -		
CHOLEST.		CHOL		CHOL		
STOOL		PAP		MAMMO-		
O.B.		TEST		GRAM		

ASSESSMENT

PLANS