University Medical Center

Updated as of 6/05/15
Supersedes all prior versions

Internal Medicine
Medical History Questionnaire
University Medical Center

NAME_____ DOB_____ AGE_____ MR#_____

PAST MEDICAL HISTORY (previous or ongoing medical conditions such as high blood pressure or diabetes)	DATE OF ONSET	NAME OF PHYSICIAN DIAGNOSING OR TREATING THE CONDITION
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

PRESCRIPTIONS TAKING INCLUDING DOSAGE AND FREQUENCY	OVER-THE-COUNTER MEDICATIONS including vitamins, laxatives, and pain medications
1. _____	1._____
2. _____	2._____
3. _____	3._____
4. _____	4._____
5. _____	5._____
6. _____	6._____
7. _____	7._____

PAST SURGERIES AND HOSPITALIZATIONS

1. _____	5._____
2. _____	6._____
3. _____	7._____
4. _____	8._____

ALLERGIES (to medications)	ALLERGIES (to food or other things)
1. _____	1._____
2. _____	2._____

SIGNATURE_____ **RELATIONSHIP TO PATIENT**_____

Internal Medicine

IMMUNIZATIONS (with date received)

1. Flu_____
2. Pneumonia_____
3. Tetanus/Diptheria_____
4. Others_____

FAMILY HISTORY AGE — ILLNESSES (if deceased, put cause and age)

Father_____ _____

Mother_____ _____

Sisters_____ _____

_____ _____

Brothers_____ _____

_____ _____

Children_____ _____

_____ _____

SOCIAL HISTORY

Marital Status (single/married/widow/divorced/separated)_____

Education (elementary/high school/ college)_____

Occupation (job/disabled) _____

Hobbies (please list)_____

Sexual Orientation (heterosexual/homosexual)_____

Military Service (branch/years served)_____

HABITS — AMOUNT/DATES OF USE

Alcohol Use _____

Tobacco Use _____

Street Drugs _____
(Including marijuana)

EXERCISE

TYPE — FREQUENCY

_____

SIGNATURE_____**RELATIONSHIP TO PATIENT**_____

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Internal Medicine Review of Symptoms (Recent or Ongoing)

Name: _____ DOB: _____ MR#_____

General
□ Chills
□ Fatigue
□ Fever
□ Malaise
□ Night Sweats
□ Weight Gain
□ Weight Loss
Other: _____

HEENT
□ Ear Drainage
□ Ear Pain
□ Eye Pain
□ Hearing Loss
□ Hoarseness
□ Nasal Drainage
□ Sinus Pressure
□ Sore Throat
□ Visual Changes
Other: _____

Respiratory
□ Chronic Cough
□ Cough
□ Known TB Exposure
□ Shortness of Breath
□ Snoring
□ Wheezing
Other: _____

Cardiovascular
□ Chest Pain
□ Leg Pain on Exertion
□ Leg Swelling
□ Palpitations
Other: _____

Gastrointestinal
□ Abdominal Pain
□ Blood in Stools
□ Change in Stools
□ Constipation
□ Diarrhea
□ Heartburn
□ Loss of Appetite
□ Nausea
□ Vomiting
Other: _____

Genitourinary (Both)
□ Burning on Urination
□ Blood in urine
□ Frequent Urination
□ Incontinence of Urine
□ Retention of Urine
□ Slow Stream
Other: _____

Reproductive (Female)
□ Abnormal PAP
□ Hot Flashes
□ Irregular Menses
□ Painful Intercourse
□ Painful Menses
□ Vaginal Discharge
□ Vaginal Dryness
□ Vaginal Itching
Other: _____

****Last Mammogram:**
_____

****Last Menstrual Cycle:**
_____

Reproductive (Male)
□ Erectile Dysfunctional
□ Decreased Libido
□ Penile Discharge
Other: _____

Skin
□ Breast Discharge
□ Breast Lump
□ Brittle Hair/Nails
□ Hair Loss
□ Hives
□ Itching
□ Mole Changes
□ Rash
□ Skin Lesion
Other: _____

Neurological
□ Dizziness
□ Gait Disturbance
□ Headache
□ Loss of Balance
□ Memory Loss
□ Numbness
□ Seizures
□ Tremors
□ Weakness
Other: _____

Psychiatric
□ Anxiety
□ Depression
□ Insomnia
Other: _____

Glandular
□ Cold Intolerance
□ Heat Intolerance
□ Excessive Thirst
□ Excessive Appetite
Other: _____

Musculoskeletal:
□ Back Pain
□ Joint Pain
□ Joint Swelling
□ Muscle Pain
□ Neck Pain
Other: _____

Hematologic
□ Easy Bleeding
□ Easy Bruising
□ Swollen Lymph Nodes
Other: _____

Immunologic
□ Contact Allergy
□ Environmental Allergy
□ Food Allergy
□ Seasonal Allergy
Other: _____