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INTERNAL MEDICINE
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Patient's Medical History

Patient's Name:	__ Male __ Female	Today's date: __ /__ / ____
Address:		DOB: __ /__ / ____
		Main Phone: ___ - ___ - ____

Family's Medical History

Epilepsy?	__Y __N	Asthma?	__Y __N	Hypertension?	__Y __N	Relationship to You:
Migraine?	__Y __N	Anemia?	__Y __N	Lipid Disorder?	__Y __N	
Mental Illness?	__Y __N	Bleed Easily?	__Y __N	Alcoholism?	__Y __N	
Glaucoma?	__Y __N	Osteoporosis?	__Y __N	Hepatitis?	__Y __N	
Diabetes?	__Y __N	Arthritis?	__Y __N	Other?		
Thyroid Disease?	__Y __N	Heart Disease?	__Y __N			
Hay Fever?	__Y __N	Stroke?	__Y __N			

Hospital Admissions

Reason		**Reason**	
	Date:__/__/____		Date:__/__/____
	Date:__/__/____		Date:__/__/____
	Date:__/__/____		Date:__/__/____

Questions about how are you feeling?

Do you have:	__Y __N	Are you feeling ill today?	__Y __N
Unexplained Weight Loss?	__Y __N	Why did you come to see Dr. Dusa today?	
Persistent Cough (for more than 2 weeks)?	__Y __N		
Night Sweats, Fever, or Chills?	__Y __N		
Is a close contact (family, friends) treated for Tuberculosis?	__Y __N		

Allergies List		**Medications You Are Currently Taking**	

Your Medical History (check all that apply)

Back pain?		Rheumatic fever?		AIDS or HIV?	
Painful to urinate?		Rubella (German measles)?		Other sexually transmitted diseases?	
Frequently urinating?		Headache?		- Types?	
Over-active bladder?		Severe?		Sexual problems?	
Urinating more than once a night?		Recurrent?		Decreased enjoyment of Life?	
Leaking urine?		Sinus trouble?		Decreased enjoyment of work?	
With __stress, __exercise,__movement? (check all that apply)					

Your Medical History Continued (check all that apply)					
Decrease in urine flow or force?		Nose bleed?		Alcohol consumption?	
Mental illness?		- Recurrent?		- Ounces per day?	
Blood in urine?		Sore Throat?		- Days per week?	
Urinary tract infection?		- Frequent?		Caffeine Consumption:	
Recurrent?		Hoarseness?		- Cups of coffee per day?	
Kidney stones?		- Prolonged?		- Cups of tea per day?	
Prostate problem?		Difficulty swallowing?		- Caffeinated drinks per day?	
- Type?		Hearing problem?		With sugar?	
Hemorrhoids?		Ringing in ear?		With artificial sweetener?	
Hernia?		Dizzy spells?		Nicotine consumption:	
Weight loss?		Fainting?		- Cigarettes?	
Weight gain?		Eye pain?		- Cigars?	
Fatigue easily?		Vision problems?		- Pipe?	
Bruise easily?		High blood pressure?		Use un-prescribed or illicit drugs?	
Cancer diagnosis?		Seizure?		- Types?	
- Type?		Stroke?		Do you exercise?	
Diabetes?		Tremors (shaking)?		__Lightly, __Moderately, __Heavily?	
Thyroid disease?		Numbness or Tingling sensations?		- How often?	
Arthritis or Rheumatism?		- Where?			
- Where?		Heartburn?		**For Ladies Only**	
Bone fracture?		Peptic ulcer?		Pregnancy:	
- Where?		Nausea?		- Number of pregnancies	
Joint injury?		Vomiting?		- Number of live births	
- Where?		Abdominal pain?		- Number of miscarriages	
Osteoporosis?		Diarrhea?		- Number of abortions	
Gout?		Constipation?		Birth control methods	
Rash?		Crohn's or Colitis?		- Type	
Hives?		Bloody or tar like stool?		- How long?	
Psoriasis?		Chest pain?		- Type	
Eczema?		Irregular pulse?		- How long?	
Trouble concentrating?		Palpitations?		- Type	
Trouble sleeping?		Heart murmur?		- How long?	
Depression?		Heart attack?		Menopausal?	
Nervousness?		Tuberculosis?		- Hot flashes?	
Moodiness?		Pneumonia or Pleurisy?		Date of last PAP test:	
Suicidal thoughts?		Bronchitis/Chronic coughs?		- Normal results?	
Memory loss?		Asthma?		- Abnormal results?	
Shortness of breath?		Wheezing?		Date of last mammogram?	
- From effort?		Leg pain?		- Normal results?	
- From lying flat?		Varicose veins?		- Abnormal results?	
Loss of Appetite?		Cold or numb feet or hands?			
Anemia?		Herpes?			
Hepatitis?		- Where?			

Please feel free to add any more information to your medical history