

Mercer Internal Medicine, LLC

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Medical History

Patient's name: _____ Age: _____ Today's date: _____

Does the patient communicate in English? Yes ___ No ___ Is the patient able to read? Yes ___ No ___

Current medical concerns and symptoms:

Previous surgeries and hospitalizations (*include dates*):

Previously diagnosed medical illnesses (circle all that apply)

Hypertension

Diabetes

High cholesterol

Hypothyroidism/Hyperthyroidism/Goiter

Glaucoma/Cataract

Coronary disease/Heart attack

Congestive heart failure

Valvular heart disease

Cardiac arrhythmia

Emphysema/Chronic bronchitis

Asthma/Hayfever/Eczema

Peptic ulcers(duodenal/gastric)

GERD/reflux/acid indigestion

Hepatitis (type if known) _____

Stroke

Seizures

Anemia

Bleeding disorder

Clots in legs/lungs (DVT/PE)

Cancer

HIV/AIDS

Tuberculosis

Obesity/Eating disorder

Other illnesses:

Current medications (including birth control pills and non-prescription drugs):

Drug and Food Allergies:

Immunizations received:

Tetanus (last vaccination _____) Influenza (last vaccination _____) Pneumovax (_____)

Other immunizations:

Additional History (circle or fill in your responses)

Do you use eyeglasses or contact lenses? Yes No

Eye doctor's name: _____

Do you use hearing aides? Yes No

Have you had colon cancer screening with colonoscopy or barium enema? Yes No

If yes, year of screening: _____ Name of GI specialist: _____

Do you smoke? Yes (packs/day: ____ starting age: ____) Quit in ____ Never smoked

Do you drink alcohol? Yes (drinks per day: ____) Occasionally (drinks per month ____) Never or rarely drink.

Do you usually wear your seat belt when in a car? Yes No

Are you at risk for sexually transmitted illnesses? Yes No Not sure

Do you have an exercise regimen to help stay physically fit? Yes No

If yes, briefly describe your routine: _____

Are you on any special type of diet? Yes No

If yes, describe your dietary regimen: _____

For women:

When was your last mammogram? _____ When was your last Pap test? _____

Name of gynecologist: _____

For men age 50 and over:

When was your last PSA blood test screening for prostate cancer? _____

Family History

Indicate which, if any, close family members suffered from the following medical conditions.

Hypertension	grandparents	father	mother	siblings	children
Diabetes	grandparents	father	mother	siblings	children
Heart attacks	grandparents	father	mother	siblings	children
Stroke	grandparents	father	mother	siblings	children
Cancer	grandparents	father	mother	siblings	children
Tuberculosis	grandparents	father	mother	siblings	children

Social History

Place of birth: _____ Marital status: _____ Number of children: _____

Occupation and place of work: _____

Special interests/hobbies: _____

Review of Symptoms

Circle the symptoms you have had **recently**. In the space to the right of the symptom, describe the **location**, **duration**, and **severity** of the symptom, as well as the circumstances under which the problem seems to occur.

Weight loss/weight gain
Fatigue/weakness
Fever/night sweats
Rash/itching
Lumps/bumps/change in mole
Headache/dizziness
Visual disturbance
Hearing loss/ringing in ears
Nasal congestion/sinus pain
Nose bleed
Throat pain/hoarseness
Swelling in the neck
Breast pain/lump/nipple discharge
Cough/sputum
Shortness of breath/wheezing
Chest pain/palpitations
Abdominal pain/heartburn
Nausea/vomiting/diarrhea
Bloody or black tarry bowel movements
Pain on urination/blood in urine
Difficulty starting or maintaining urine flow
Involuntary leakage of urine
Unusually frequent urination
Discharge from penis or vagina
Problems with sexual functioning
Joint pain/stiffness
Backache/muscle pain
Cold feet/hands
Cramps in legs with walking
Leg/ankle swelling
Fainting/blackouts
Numbness
Tremors
Confusion/memory difficulties
Localized weakness/paralysis
Nervousness/depression
Insomnia
Heat or cold intolerance
Excessive sweating
Excessive thirst, hunger, or urination
Easy bruising or bleeding

For women only: Number of Pregnancies:

Number of deliveries:

Birth control method:

Last menstrual period:

Irregular or heavy periods?

Painful periods?