Integrated Medical Services (IMS)

Health History Form

Your answers to this form will help your healthcare providers better understand your medical concerns and conditions.

Name_____Date of Birth_____Age_____Todays Date_____

PAST MEDICAL HISTORY

Medical Problems/Hospitalizations (i.e. diabetes, cancer high blood pressure, high cholesterol, depression, etc)	**Surgical History** (i.e. tonsillectomy, appendectomy, hernia, hysterectomy, colonoscopy, etc.) include month/year

FAMILY MEDICAL HISTORY

Father ☐Living, Any Medical Conditions:_____

☐Deceased, cause of death:_____

Mother ☐Living, Any Medical Conditions:_____

☐Deceased, cause of death:_____

Brothers____# ☐Living, Any Medical Conditions:_____

☐Deceased, cause of death:_____

Sisters ____# ☐Living, Any Medical Conditions:_____

☐Deceased, cause of death:_____

Specific Illness in Family History: (i.e. colon ca, breast ca, prostate ca, heart disease, stroke, etc.) ☐None
If so, please state disease and who?_____

SOCIAL HISTORY

Tobacco Use: ☐ Never ☐ Former ☐ Current ____#Packs/Day ____#Years Stopped Smoking Date: _____

Alcohol: ☐ None ☐ Rarely ☐ Social ☐ 1-2 drinks/day ☐ greater than 2 drinks/day ☐ greater than 6 drinks/day

Is your alcohol use a concern for you or others? ☐ No ☐ Yes

Illicit Drug Use: ☐ Never ☐ Former ☐ Current: _____ Stopped Use Date:_____

Caffeine Use: ☐ None ☐ Coffee ☐ Tea ☐ Soda _____# cups/day

Education: ☐ High School ☐ Some College ☐ Degree (s) _____

Occupation: _____ ☐ Retired, _____Year

Marital Status: ☐ Single ☐ Married _____years ☐ Divorced ☐ Widowed Spouse's Name:_____
Number of children/ages?_____
Special Interests/Hobbies:
_____

Do you have Advanced Directives? ☐ Yes ☐ No **Power of Attorney for Medical Care?**_____

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Allergies (If any, please list name of agent and reaction such as rash/hives, swelling) ☐ No Known Drug Allergies

_____

_____

Current Prescription Medications ☐ NONE

Name	Dose	How Often	Reason for Use

Non-Prescription/Herbals/OTC/Vitamins ☐ NONE

Name	Dose	How Often	Reason for Use

PREVENTATIVE SCREENING/IMMUNIZATIONS

Exam/Test (*indicate last date performed*)		**Immunizations (*indicate last date administered*)**	
☐ Cholesterol (Lipid Panel)	_____	☐ Pneumovax (Pneumonia)	_____
☐ Glucose (Diabetes)	_____	☐ Prevnar 13 (Pneumonia)	_____
☐ Cardiovascular Disease (EKG)	_____	☐ Influenza (Flu)	_____
☐ Osteoporosis(Bone Density)	_____	☐ Zostavax (Shingles)	_____
☐ Prostate Cancer (PSA/DRE)	_____	☐ Tdap (Tetanus/diphtheria/Pertussis)	_____
☐ Breast Cancer (Mammogram)	_____	☐ Td (Tetanus/diphtheria)	_____
☐ Cervical Cancer (Pap Smear)	_____	☐ HPV/Gardasil	_____
☐ Colon Cancer (Colonoscopy)	_____	☐ Hepatitis B	_____
☐ Lung Cancer (Chest Xray)	_____	☐ Hepatitis A	_____
☐ Abdominal Aorta (AAA)	_____	☐ Other:_____	_____
☐ Carotid Disease (Ultrasound)	_____		
☐ Echocardiogram	_____		
☐ Other: _____	_____		

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REVIEW OF SYSTEMS Please check any recent or recurring problems:

Constitutional
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain_____lbs
- ☐ Weight Loss_____lbs
- ☐ Exercise Intolerance

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Changes
- ☐ Cataract History

Ears/Nose/Mouth/Throat
- ☐ Ringing in Ears
- ☐ Difficulty Hearing
- ☐ Dizziness/Vertigo
- ☐ Ear Pain
- ☐ Nose/Sinus Issues
- ☐ Snoring
- ☐ Frequent Colds
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Frequent Sore Throats
- ☐ Hoarseness
- ☐ Bleeding Gums
- ☐ Dry Mouth
- ☐ Mouth Breathing
- ☐ Mouth Ulcers

Respiratory
- ☐ Cough
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ Pain with Breathing
- ☐ Wheezing
- ☐ Snoring
- ☐ Sleep Apnea

Cardiovascular
- ☐ Arm Pain with Exertion
- ☐ Chest Pain with Exertion
- ☐ Chest Heaviness
- ☐ Irregular Heart Beats
- ☐ Known Heart Murmur
- ☐ Lightheaded on Standing
- ☐ Shortness of Breath w/Exertion
- ☐ Swelling (Edema)

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands
- ☐ Anemia

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black/Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Indigestion ☐ Heartburn
- ☐ Frequent Belching
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Pain with Urination
- ☐ Incomplete Emptying
- ☐ Urinary Loss of Control
- ☐ Urinary Frequency
- ☐ Urinary Urgency
- ☐ Urinary Hesitancy
- ☐ Post-Void Dribbling
- ☐ Erectile Dysfunction

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness
- ☐ Fractures
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Use of Assist Device

Neurologic
- ☐ Dizziness/Vertigo
- ☐ Poor Balance
- ☐ Headaches
- ☐ Migraine
- ☐ Memory Loss
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Anxiety
- ☐ Stress
- ☐ Panic Attacks
- ☐ Depression
- ☐ Mania
- ☐ Sleep Problems
- ☐ Alcohol Overuse
- ☐ History of Addiction
- ☐ Suicidal Thoughts
- ☐ Do not feel safe

Integumentary(Skin)
- ☐ Change in Mole
- ☐ Dry Skin
- ☐ Eczema
- ☐ Rash
- ☐ Growth/Lesion
- ☐ Itching
- ☐ Jaundice (yellow skin/eye)

Allergic/Immunologic
- ☐ Sneezing
- ☐ Hives/Rash
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Men Only
- ☐ Pain or Lump in Testicle
- ☐ Penis Burning/Itching/Discharge
- ☐ Prostate Disease/Problems
- ☐ Night-time urination
- ☐ Sexual problems/concerns
- ☐ Low sex drive

Women Only
- ☐ Vaginal Itching/Burning/Discharge
- ☐ Night time urination
- ☐ Breast Tenderness/Discharge
- ☐ Breast Lump
- ☐ Ovarian Cysts

Total Pregnancies _____

Births _____

Miscarriages _____

Abortions _____

Age Menses/Period Started _____