Garner Internal Medicine
History Form

Patient Name: ________________________________ Date: __________

Please check all that you have a personal history of:

() Asthma
() COPD
() Pneumonia
() High blood pressure
() High cholesterol
() Heart attack
() Heart murmur
() Artificial heart valve
() Atrial Fibrillation
() Eye disease
() Hearing disorder
() Cancer: type________________
() Seizures
() Migraines
() Stroke
() Neck/back pain
() Osteoporosis
() Kidney disease
() Hepatitis
() Incontinence
() GERD (reflux)
() Diabetes
() HIV
() Anemia
() Bleeding disorder
() Blood clot
() Thyroid disorder
() Depression
() Anxiety
() Mental illness: Type___________
() Fibromyalgia
() Other: ______________________
____

Please list all surgeries and date of surgeries if known:
____
____
____

Please list all doctors that you currently see:
____
____
____

Social History:

Marital Status: (circle one) Single Married Widowed Divorced
Do you use alcohol? YES or NO If yes, how many drinks per week? ___per day? ___
Do you use tobacco or e- cigarette? YES or NO If yes, what type_________________
If YES, How much per day? ___________Age started? ____ Age Quit? _______
Employment status (circle) WORKING RETIRED DISABLED: reason_______
Occupation: _________________________
Do you always wear a seatbelt? YES or NO____
Do you have children? YES or NO___ If yes, what are their birth years?______________

Family History:

Father: Living: Yes or no? ____ Approximate age of death if deceased_____
Medical problems and age of onset if known:_________________________
____

Mother: Living: Yes or no? ____ Approximate age of death if deceased_____
Medical problems and age of onset if known:_________________________
____

Brothers: Living: Yes or no? ____ Approximate age of death if deceased_____
Medical problems and age of onset if known:_________________________
____

Sisters: Living: Yes or no? ____ Approximate age of death if deceased_____
Medical problems and age of onset if known:_________________________
____

Family history of alcohol abuse? Yes or no____
Family history of depression? Yes or no____

Immunizations/Screening Tests:

Tetanus vaccination_______________
Pneumonia vaccination_____________
Shingles vaccination_______________
Gardasil/HPV vaccination__________
Hepatitis B vaccination_____________
Flu vaccination__________________
Tdap vaccination_________________
PPD____________________________

Colonoscopy________________
PSA________________________
Eye exam___________________
Stress test__________________
Bone density test_____________
Sleep study__________________
Mammogram________________

Review of Systems: (Please circle any of the following that you are experiencing)

weight loss/gain
fevers
headaches
rash
itching
hives
congestion
ear pain
sore throat
chest pain
leg swelling
palpitations
cough
wheezing
shortness of breath
nausea
diarrhea

abdominal pain
urinary frequency
incontinence
burning with urination
vaginal discharge
irregular periods
erectile dysfunction
joint pain
muscle spasm
neck/back pain
heat/cold intolerance
seizures
numbness
dizziness
depression
anxiety
trouble sleeping

Advanced Directives:

Do you have a Living Will? Yes or no_______
Do you have a Power of Attorney for health care? Yes or no______
If yes, Name/Phone #____