



WEDDINGTON
 INTERNAL MEDICINE & PEDIATRICS
 An affiliate of NorthEast Medical Center

PATIENT HISTORY

Date _____

Name _____ Date of birth _____ Sex M _____ F _____

Occupation _____ Marital Status Single _____ Married _____

Divorced _____ Widowed _____

Race _____ Age _____

PAST MEDICAL HISTORY Have you ever had any of the following? (Circle)

- | | | | |
|---------------------|-------------------|------------------------------|--------------------|
| Glaucoma | Asthma | Kidney stone | Arthritis |
| Cataracts | Emphysema | Kidney infections | Low back problems |
| Sinus troubles | Tuberculosis | Bladder infections | Migraine headaches |
| Allergies | Pneumonia | Prostate trouble | Seizures |
| High blood pressure | Stomach ulcers | HIV | Depression |
| Angina | Hepatitis | Sexually transmitted disease | Anxiety |
| Heart murmur | Gallstones | Skin cancer | Panic attacks |
| Stroke | Irritable bowel | High cholesterol | |
| Phlebitis | Blood transfusion | Thyroid problems | |
| Sickle cell anemia | | Diabetes | |

Other serious illness: _____

OPERATIONS (Give date or age)

- | | | | |
|-----------------|----------------------|----------------|--------------------|
| Tonsils _____ | Gallbladder _____ | Appendix _____ | Hysterectomy _____ |
| Prostate _____ | Hernia _____ | Heart _____ | Breast _____ |
| Vasectomy _____ | Tubal ligation _____ | | |

Other _____

OTHER HOSPITALIZATIONS _____

CURRENT MEDICATIONS: (Give name and does)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

ALLERGIES: (Medications, Foods, Pollens, etc.)

IMMUNIZATIONS (Approximate date or age)

- | | | | |
|-------------------|-----------------|---------------|-----------------|
| PPD _____ | Pneumonia _____ | Tetanus _____ | Hepatitis _____ |
| Flu Vaccine _____ | | | |

FAMILY HISTORY

	Age	Alive	Deceased	Health Problems
Father				
Mother				
Sister				
Sister				
Brother				
Brother				
Children				

HABITS Do you

	Yes	No	Amount/Type
Use tobacco (cigarettes, cigars, chewing tobacco)			
Use alcohol (beer, wine, liquor)			
Use caffeine (coffee, tea, colas)			
Diet (restrictions, special diet)			
Exercise regularly			
Wear seat belts?			

Who lives with you? _____

Highest educational level achieved _____

FOR WOMEN

Age at first period _____ Date of last period _____

Regular Periods? Yes _____ No _____ Interval between periods _____ Length of periods _____

Pregnancies _____ Live births _____ Miscarriages _____ Abortions _____ Still births _____

Birth control method _____ Doing monthly self breast exam? _____

WHEN DID YOU LAST HAVE THESE PERFORMED?

Cholesterol _____ Complete physical _____

Stool for blood _____

For men: Prostate exam _____

For women: Pap smear _____ Mammogram _____

WHAT ARE YOUR MOST IMPORTANT PROBLEMS OR QUESTIONS TODAY?
