

Internal Medicine Group

Patient Name _____ Today's Date _____

Date of Birth _____ Physician _____

Reason for visit _____

List all current meds and dosages: _____

List all medication allergies and reaction that occurs: _____

List all chronic medical problems and surgeries: _____

Family History (circle all that apply)

Mother: Living Deceased (age and cause of death) _____

High Blood Pressure Diabetes Heart Disease Stroke Cancer Other _____

Father: Living Deceased (age and cause of death) _____

High Blood Pressure Diabetes Heart Disease Stroke Cancer Other _____

Brothers (number of) _____ Sisters (number of) _____

Health problems in any siblings:

High Blood Pressure Diabetes Heart Disease Stroke Cancer Other _____

Social History (circle reply)

Marital Status S M W D Number of children _____

Cigarette Use No Yes How much per day? _____

Alcohol Use No Yes How much per week? _____

Employed No Yes Type of work? _____

Physician _____ Date _____