IMS
INTERNAL MEDICINE SPECIALISTS

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MEDICAL HISTORY

PATIENT'S NAME: _____ **DATE:** _____

DOB: _____ **AGE:** _____ **GENDER:** ☐ **Male** ☐ **Female** **SSN:** _____

ALLERGIES

NAME OF DRUG OR TYPE OF ALLERGY	REACTION

CURRENT MEDICATION(S)

MEDICATION	DOSAGE	MEDICATION	DOSAGE

MEDICAL HISTORY

Please indicate whether you have ever had any of the following . . .

YES	NO	CONDITION	YES	NO	CONDITION
☐	☐	High Blood Pressure	☐	☐	Asthma
☐	☐	Heart Attack / MI	☐	☐	Kidney Stone
☐	☐	Diabetes	☐	☐	Kidney Disease
☐	☐	Stomach Ulcer	☐	☐	Pneumonia
☐	☐	Gout	☐	☐	Arthritis
☐	☐	Liver Disease / Hepatitis	☐	☐	Gallbladder Disease
☐	☐	Thyroid Disease	☐	☐	Increased Cholesterol
☐	☐	Psoriasis	☐	☐	Heart Murmur
☐	☐	Cancer	☐	☐	Anemia
☐	☐	Stroke	☐	☐	Blood Transfusion
☐	☐	Accident / Broken Bone(s) _____			
☐	☐	Other (not listed) _____			

HOSPITALIZATION / SURGERY

YEAR	HOSPITAL / CITY	REASON	PHYSICIAN

FEMALES ONLY Are you currently pregnant? ☐ YES ☐ NO Could you possibly be pregnant? ☐ YES ☐ NO

Date of Last Menstrual Period: _____

FAMILY HISTORY

YES	NO	CONDITION	RELATIONSHIP
☐	☐	Heart Disease	☐ Father ☐ Mother ☐ Sibling ☐ Other: _____
☐	☐	Diabetes	☐ Father ☐ Mother ☐ Sibling ☐ Other: _____
☐	☐	Stroke	☐ Father ☐ Mother ☐ Sibling ☐ Other: _____
☐	☐	Asthma	☐ Father ☐ Mother ☐ Sibling ☐ Other: _____
☐	☐	Epilepsy	☐ Father ☐ Mother ☐ Sibling ☐ Other: _____
☐	☐	Bleeding Disorder	☐ Father ☐ Mother ☐ Sibling ☐ Other: _____
☐	☐	Thyroid Disease	☐ Father ☐ Mother ☐ Sibling ☐ Other: _____
☐	☐	Cancer	☐ Father ☐ Mother ☐ Sibling ☐ Other: _____
☐	☐	High Blood Pressure	☐ Father ☐ Mother ☐ Sibling ☐ Other: _____
☐	☐	High Cholesterol	☐ Father ☐ Mother ☐ Sibling ☐ Other: _____
☐	☐	Other:	☐ Father ☐ Mother ☐ Sibling ☐ Other: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

HABITS

Do you now or have you ever smoked?	☐ YES	☐ NO	cigarettes/day	_____	Since when?	_____
Do you drink alcohol?	☐ YES	☐ NO	glasses/week	_____	Since when?	_____
Do you use recreational drugs, e.g. marijuana?	☐ YES	☐ NO	frequency	_____	Since when?	_____

REVIEW OF SYSTEMS

Please check any problems that apply to you at this time

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Recent Weight Gain
- ☐ Recent Weight Loss
- ☐ Weakness

LUNGS
- ☐ Cough
- ☐ Coughing With Blood
- ☐ Difficulty Breathing
- ☐ Shortness of Breath
- ☐ Wheezing

ENDOCRINE
- ☐ Coarse Hair
- ☐ Cold/Heat Intolerance
- ☐ Dry Skin
- ☐ Early Menstrual Flow

CARDIOVASCULAR
- ☐ Chest Pain/Tightness
- ☐ Heart Murmur
- ☐ Irregular Heartbeat
- ☐ Passing Out

GYNECOLOGICAL
- ☐ Last Menstrual Period
- ☐ Vaginal Bleeding
- ☐ Vaginal Dryness

GASTROINTESTINAL
- ☐ Black Stool
- ☐ Blood in Stool
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting of Blood
- ☐ Yellow Jaundice

GENITOURINARY
- ☐ Blood In Urine
- ☐ Difficulty/Burning
- ☐ Incontinence (urinary)
- ☐ Penile Discharge
- ☐ Prostate Issue

DERMATOLOGICAL
- ☐ Acne
- ☐ Mole(s)
- ☐ Skin Itching
- ☐ Skin Rash

NEUROLOGICAL
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Weakness
  - ☐ Right:
  - ☐ Left:

EYES
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye Drainage
- ☐ Eye Exam (abnormal)
- ☐ Eye Redness

H E N T
- ☐ Change in Voice
- ☐ Decreased Hearing
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Headache
- ☐ Hoarseness of Voice
- ☐ Throat Pain

MUSCLES / JOINTS
- ☐ Joint Swelling/Pain
- ☐ Muscle Stiffness
- ☐ Muscle Spasm

SCREENING PROCEDURE(S)

Last EKG	**DATE:**		**Last Chest Xray . . . . . .**	**DATE:**	
Last Treadmill	**DATE:**		**Last Blood Work . . . . . .**	**DATE:**	
Last Sigmoid/Colonoscopy .	**DATE:**		**Last Dexascan . . . . . .**	**DATE:**	

FEMALES ONLY

Last Pap Smear	**DATE:**		**Last Mammogram . . . . . .**	**DATE:**	

I certify that the above information is true to the best of my knowledge.

PATIENT'S NAME: _____

_____ _____

PATIENT'S SIGNATURE **DATE**