Name:	Date of Birth:	Today's Date:

What is the main reason for your visit today?_____

Are there any other health problems would you like to address today?_____

Are you currently receiving care for any medical conditions? ◯ *Yes* ◯ *No* *If yes, please list your other physicians or specialists from whom you are currently receiving treatment:*

_____ _____ _____

_____ _____ _____

I. PAST MEDICAL HISTORY:

Have you ever had or currently have any of the following? (Please Circle Below)

Anemia ☐	Diabetes: Type I ☐ / Type II ☐	Pneumonia ☐
Allergies ☐	Eye Disease ☐	Rheumatic Fever ☐
Anxiety and/or Depression ☐	GERD ☐	Sleep Apnea ☐
Arthritis ☐	Glaucoma ☐	Sexually Transmitted Disease ☐
Asthma ☐	Heart Disease / Disorders ☐	Stroke ☐
Back Problems ☐	Heart Murmur ☐	Thyroid Disorder ☐
Bladder Infections ☐	Hepatitis: A ☐ / B ☐ / C ☐	Ulcer ☐
Bleeding Disorder ☐	High Blood Pressure ☐	Tuberculosis ☐
Blood Transfusion ☐	High Cholesterol ☐	Whooping Cough ☐
Cancer: ☐	Kidney Disease ☐	Other: ☐

II. PAST SURGICAL HISTORY:

Type of Surgery	Date of Surgery	Surgeon

III. ALLERGIES:

Please list all adverse reactions you may have to medications, foods or other substances:

Medication or Substance	Type of Reaction

IV. FAMILY MEDICAL HISTORY:

Ethnic Background: (We ask for this information because some clinical screenings differ based, in part, on ethnicity)

☐ *African-American* ☐ *Asian* ☐ *Caucasian* ☐ *Hispanic* ☐ *Native American* ☐ *Other*

	Living	Deceased	Sex	Age: current or at death	Medical Conditions or Diseases
Parent	○	○	M○ F○		
Parent	○	○	M○ F○		
Sibling	○	○	M○ F○		
Sibling	○	○	M○ F○		
Sibling	○	○	M○ F○		
Children	○	○	M○ F○		
Children	○	○	M○ F○		
Children	○	○	M○ F○		
Other	○	○	M○ F○		

Has any family member developed heart problems before the age of 60? ○Y ○ N Relationship:_____

Has any family member developed cancer? ○Y ○ N Relationship:_____ Type:_____

V. SOCIAL HISTORY:

Please check all applicable answers for each category:

Marital Status:	Single ○	Married ○	Widowed ○	Separated/Divorced ○
Sexual Preference:	Heterosexual ○	Bisexual ○	Homosexual ○	
Sexual Practices:	Abstinent ○	Monogamous ○ -or- Multiple Partners ○	No Birth Control ○ -or- Birth Control ○ -or- Vasectomy / Tubal Ligation ○	Practicing Safe Sex ○ -or- Not Practicing Safe Sex ○

Tobacco Use:	Never ○	Previous ○ Year Quit:____ Packs Daily: ____	Current ○ Packs Daily: ____	
Alcohol Use:	Never ○	1-2 drinks/wk ○	3-5 drinks/wk ○	6-10 drinks/wk ○
Illegal Drug Use:	Never ○	Prior ○	Current ○	
Exercise:	Never ○	Light Activity: ○ *(i.e. standing or casual walking)* Hours per Week: ☐	Moderate Activity: ○ *(i.e. easy bicycling or light yard work)* Hours per Week: ☐	Vigorous Activity: ○ *(i.e. any activity that causes you to sweat or heart to beat rapidly)* Hours per Week: ☐
Caffeine:	Never ○	1-2 drinks/day ○	3-5 drinks/day ○	6-10 drinks/day ○
Vehicle Safety	Seat Belts	Yes ○	No ○	

VI. MEDICATIONS:

Please list all current medications:

Medication	Dose	Frequency	Medication	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

VII. PREVENTATIVE HEALTH MAINTENANCE

Please provide us with the following information to the best of your ability:

	Yes	No	Do Not Know	Date
Are your Immunizations Current?:	○	○	○	
Prior Tetanus Shot:	○	○	○	
Prior Influenza Vaccine:	○	○	○	
Prior Pneumovax (Pneumonia) Vacinne:	○	○	○	
Prior Bone Density Screening Examination	○	○	○	
Prior Colon Cancer Screening Examination	○	○	○	
Prior Cholesterol Screening	○	○	○	
Prior Cardiac Stress Testing	○	○	○	
Prior HIV / AIDS Test:	○	○	○	

MALES

Prior Prostate Exam: Y ○ N ○ Unsure ○

Date if known: _____

Prior PSA Test: Y ○ N ○ Unsure ○

Date if known: _____

FEMALES

Prior Pelvic Exam: ○Y ○N ○ Unsure Date if known: _____

Prior Pap Smear: ○Y ○N ○ Unsure Date if known: _____

* Any previous Abnormal Pap Smears?○Y ○ N ○ Unsure

Prior Breast Exam: ○Y ○N ○ Unsure Date if known: _____

Prior Mammogram:○Y ○ N ○ Unsure Date if known: _____

SMOKERS

Prior Chest X-Ray: ○ Y ○ N ○ Unsure Date if known: _____

Prior Pulmonary Function Test (Breathing Studies):○Y ○ N ○ Unsure Date if known: _____

Prior Attempts to Quit Smoking: ○Y ○N Are you interested in discussing smoking cessation today? ○Y ○N

VIII. MISCELLANEOUS

How did you hear about Irvine Internal Medical Group? _____