InvisionHealth
peace of mind

Brain and Spine Center

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Internal Medicine
Adult History for NEW Patients

Your anwsers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all four pages. If you cannot remember specific details, please provide your best guess.

Main reason for today's visit:_____

Other concerns:_____

What are your health goals for the next year?_____

Where were you getting your care before?_____

REVIEW OF SYMPTOMS: Please mark the box and/or circle any **persistent** symptoms you have had in the past few months. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

General
- ☐ Unexplained weight loss / gain
- ☐ Unexplained fatigue / weakness
- ☐ Fall asleep during day when sitting
- ☐ Fever, chills
- ☐ **No problems**

Skin
- ☐ New or change in mole
- ☐ Rash / itching
- ☐ **No problems**

Breast
- ☐ Breast lump / pain / nipple discharge
- ☐ **No problems**

Ears/Nose/Throat
- ☐ Nosebleeds, trouble swallowing
- ☐ Frequent sore throat, hoarseness
- ☐ Hearing loss / ringing in ears
- ☐ **No problems**

Eyes
- ☐ Change in vision / eye pain / redness
- ☐ **No problems**

Cardiovascular
- ☐ Chest pain / discomfort
- ☐ Palpitations (fast or irregular heartbeat)
- ☐ **No problems**

Respiratory
- ☐ Cough / wheeze
- ☐ Loud snoring / altered breathing during sleep
- ☐ Short of breath with exertion
- ☐ **No problems**

Gastrointestinal
- ☐ Heartburn / reflux / indigestion
- ☐ Blood or change in bowel movement
- ☐ Constipation
- ☐ **No problems**

Genitourinary
- ☐ Leaking urine
- ☐ Blood in urine
- ☐ Nightime urination or increased frequency
- ☐ Discharge: penis or vagina
- ☐ Concern with sexual function
- ☐ **No problems**

Musculoskeletal
- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle / joint pain
- ☐ **No problems**

Endocrine
- ☐ Heat or cold sensitivity
- ☐ **No problems**

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Easy bruising
- ☐ **No problems**

Neurological
- ☐ Headache
- ☐ Memory loss
- ☐ Fainting
- ☐ Dizziness
- ☐ Numbness / tingling
- ☐ Unsteady gait
- ☐ Frequent falls
- ☐ **No problems**

Allergic/Immune
- ☐ Hay fever / allergies
- ☐ Frequent infections
- ☐ **No problems**

Psychiatric
- ☐ Anxiety / stress / irritability
- ☐ Sleep problem
- ☐ Lack of concentration
- ☐ **No problems**

Women only
- ☐ Pre-menstrual symptoms (bloating, cramps, irritability)
- ☐ Problem with menstrual periods
- ☐ Hot flashes / night sweats
- ☐ **No problems**

Immunizations: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. ☐

Tetanus(Td)☐__With Pertussis(Tdap)☐__Varicella(Chicken Pox) shot or illness☐__Pneumovax(pneumonia)☐__
Influenza(flu shot)☐__Hepatitis A☐__Hepatitis B☐__MMR☐__Meningitis☐__Zostavax(shingles)☐__HPV☐__

Patient Name (print) _____ Date_____ Medical Staff initials_____

Patient Signature_____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if needed.

☐ TAKE NO MEDICATIONS

Medication Dose (e.g. mg/pill) How many times per day?

_____

_____

_____

_____

_____

Allergies or intolerance to medications (include type of reaction):_____

_____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol)	Date_____	Abnormal?	☐ No ☐ Yes
Colonoscopy/Sigmoidoscopy	Date_____	Polyp?	☐ No ☐ Yes
Women only:			
Mammogram	Date_____	Abnormal?	☐ No ☐ Yes
Pap Smear	Date_____	Abnormal?	☐ No ☐ Yes
Bone Density Test	Date_____	Abnormal?	☐ No ☐ Yes

PERSONAL MEDICAL HISTORY:

Condition	*Current*	*Past*
Alcohol / Drug Abuse	☐	☐
Allergy (Hay Fever)	☐	☐
Anemia	☐	☐
Anxiety	☐	☐
Arthritis (Rheumatoid)	☐	☐
Arthritis (Osteoarthitis)	☐	☐
Asthma	☐	☐
Bladder / Kidney Problems	☐	☐
Blood Clot (leg)	☐	☐
Blood Clot (lung)	☐	☐
Blood Transfusion	☐	☐
Breast Lump (benign)	☐	☐
Cancer Breast	☐	☐
Cancer Colon	☐	☐
Cancer Other Type	☐	☐
Cancer Ovarian	☐	☐
Cancer Prostate	☐	☐
Cataracts	☐	☐
Chicken Pox	☐	☐
Colon Polyp	☐	☐
Coronary Artery Disease	☐	☐
Depression	☐	☐
Diabetes (adult onset)	☐	☐
Diabetes (childhood onset)	☐	☐
Diverticulosis	☐	☐
Emphysema	☐	☐
Fractures (broken bone)	☐	☐
Gallbladder Disease	☐	☐
Gastroesophageal Reflux- (Heartburn/GERD)	☐	☐
Glaucoma	☐	☐
Other (list)	☐	☐

Condition	*Current*	*Past*
Gout	☐	☐
Gynecological Conditions (Endometriosis)	☐	☐
Gynecological Conditions (Fibroids)	☐	☐
Gynecological Conditions (Other)	☐	☐
Heart Attack	☐	☐
Hepatitis- Type A	☐	☐
Hepatitis- Type B	☐	☐
Hepatitis- Type C	☐	☐
Hepatitis- Other	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Hip Fracture	☐	☐
Irritable Bowel Syndrome	☐	☐
Kidney Disease / Failure	☐	☐
Kidney Stones	☐	☐
Liver Disease	☐	☐
Migraine Headaches	☐	☐
Osteoporosis	☐	☐
Pneumonia	☐	☐
Prostate (enlargement)	☐	☐
Prostate (nodules)	☐	☐
Seizure / Epilepsy	☐	☐
Skin Condition (Eczema)	☐	☐
Skin Condition (Psoriasis)	☐	☐
Skin Condition (Abnormal Moles)	☐	☐
Sleep Apnea	☐	☐
Stomach Ulcer	☐	☐
Stroke	☐	☐
Thyroid (Nodule)	☐	☐
Thyroid High (Overactive) / Hyperthyroidism	☐	☐
Thyroid Low (Underactive) / Hypothyroidism	☐	☐
Other (list)	☐	☐

Patient Name (print) _____ Date_____ Medical Staff initials_____

Patient Signature_____

Surgical Procedure	*Yes*	*Year*	*Comments*
Abdominal Surgery	☐		
Appendectomy (appendix removal)	☐		
Back Surgery (lumbar)	☐		
Biopsy (location)	☐		
Breast Biopsy	☐		Right ○ Left ○ Both ○
Breast Surgery	☐		Right ○ Left ○ Both ○
Colonoscopy	☐		
Coronary Bypass	☐		
Coronary Stent	☐		
EGO (Stomach Endoscopy)	☐		
Cataract	☐		
Gallbladder Removal	☐		Laparoscopic ☐
Heart Surgery (other than coronary bypass)	☐		
Hip Surgery	☐		Right ○ Left ○ Both ○
Hysterectomy (total, including ovaries)	☐		Laparoscopic ○ Vaginal ○ Abdominal ○
Hysterectomy (partial, ovaries left)	☐		Laparoscopic ○ Vaginal ○ Abdominal ○
Knee Surgery	☐		Right ○ Left ○ Both ○
LEEP (Cervix Surgery)	☐		
Neck Surgery	☐		
Ovary Ligation (“Tubal”)	☐		
Ovary Surgery	☐		Right ○ Left ○ Both ○
Vasectomy	☐		
Sigmoidoscopy	☐		
Sinus Surgery	☐		
Other (list)	☐		

FAMILY HISTORY: Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	*Mother*	*Father*	*Sister(s)*	*Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	*Other Relative*	*Comments*
No significant history known	☐	☐	☐	☐	☐	☐	☐	☐		
Alcoholism / Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐		
Alzheimers	☐	☐	☐	☐	☐	☐	☐	☐		
Asthma	☐	☐	☐	☐	☐	☐	☐	☐		
Autoimmune Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Bleeding or Clotting Disorder	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer Breast	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer Colon	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer Other Type	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer Ovarian	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer Prostate	☐	☐	☐	☐	☐	☐	☐	☐		
Colon Polyp	☐	☐	☐	☐	☐	☐	☐	☐		
Coronary Artery Disease (e.g. heart attack, angina)	☐	☐	☐	☐	☐	☐	☐	☐		
Depression / Suicide / Anxiety	☐	☐	☐	☐	☐	☐	☐	☐		
Diabetes (childhood onset)	☐	☐	☐	☐	☐	☐	☐	☐		
Diabetes (adult onset)	☐	☐	☐	☐	☐	☐	☐	☐		
Emphysema (COPD)	☐	☐	☐	☐	☐	☐	☐	☐		
Genetic Disorder (explain)	☐	☐	☐	☐	☐	☐	☐	☐		
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐		
Heart Disease (CHF)	☐	☐	☐	☐	☐	☐	☐	☐		
Heart Disease (Other)	☐	☐	☐	☐	☐	☐	☐	☐		
Hepatitis B or C	☐	☐	☐	☐	☐	☐	☐	☐		
High Blood Pressure- Hypertension	☐	☐	☐	☐	☐	☐	☐	☐		
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐		
Hip Fracture	☐	☐	☐	☐	☐	☐	☐	☐		
Hypothyroidism / Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Kidney Stones	☐	☐	☐	☐	☐	☐	☐	☐		
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐		
Migrane Headaches	☐	☐	☐	☐	☐	☐	☐	☐		
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐		
Other (list)	☐	☐	☐	☐	☐	☐	☐	☐		

Patient Name (print) _____ Date_____ Medical Staff initials_____

Patient Signature_____

OTHER HEALTH ISSUES:

Tabacco Use
Smoke cigarettes: ☐Never ☐No ☐Yes
(If you never smoked please go to alcohol use question now)

Quit date:_____ How many years did you smoke?_____

Approximately how many packs a day did you smoke?_____

Current smoker: Pack(s)/day:_____ # of years: _____

Other tobacco: ☐Pipe ☐Cigar ☐Snuff ☐Chew

Alcohol Use
Do you drink alcohol? ☐No ☐Yes
# of drinks/week:_____ ☐Beer ☐Wine ☐Liquor

Drug Use
Do you use marijuana or recreational drugs? No ☐ Yes ☐
Have you ever used needles to inject drugs? No ☐ Yes ☐

Sexual Activity
Sexually involved currently. ☐No ☐Yes
Sexual partner(s) is/are/have been ☐male ☐female
Birth control method (circle below all that apply) None ☐
Condom, pill, diaphragm, vasectomy, other_____

Exercise: Do you exercise regularly? ☐No ☐Yes
What kind of exercise?_____
_____
How long(minutes)?_____ How often?_____

Diet: How would you rate your diet? ☐Good ☐Fair ☐Poor
Would you like advice on your diet? ☐No ☐Yes

Safety: Do you use a bike helmet? ☐No bike ☐No ☐Yes
Do you use seatbelts consistently? ☐No ☐Yes
Does your home have a working smoke detector?
☐No ☐Yes

If you have guns in your home, are they locked up?
☐Not applicable ☐No ☐Yes

Is violence at home a concern to you? ☐No ☐Yes

Have you completed an Advance Directive for Health Card (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)
(circle above all that apply) ☐No ☐Yes

SOCIAL HISTORY:

Occupation (or prior occupation):_____Retired/Unemployed/Leave of absence/Disabled(circle one)
Employer:_____Years of education or highest degree:_____
Marital status (circle one) Single,Partner,Married,Divorced,Widowed,Other:_____
Spouse/partner's name:_____Number of children:_____Ages if under 18 years:_____
Number of grandchildren:_____Number of great grandchildren:_____
Who lives at home with you?_____
Leisure avtivities, group involvement, volunteer work, recent travel:_____
_____
_____

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____
Date (month/day if known) of last menstrual period if you are still menstruating: _____
Age at beginning of periods (menstruation): _____
Age at end of periods (menopause): _____

Other comments:_____
_____
_____
_____

Patient Name (print) _____ Date_____ Medical Staff initials_____

Patient Signature_____