CLARKSVILLE INTERNAL MEDICINE - MEDICAL HISTORY FORM

NAME: ___________________________________ DOB: ________________ GENDER: ___ Male ___ Female

PRIMARY LANGUAGE SPOKEN: ______ ENGLISH ; ______ SPANISH ; _____ OTHER (____________________)

	American Indian		Caucasian / White	**ADVANCE DIRECTIVES:**
	Alaska Native		Hispanic / Latino	**Medical Living Will ______ YES;______NO**
	African American/Black		Native Hawaiian/Pacific Islander	**Med. Power of Attorney ____ YES;_____ NO**
	Asian		Other Ethnicity :	Not sure/ do not know: ______________

SMOKING HISTORY					
	_______ NEVER SMOKED OR USED TOBACCO PRODUCTS _______ SMOKED or USED TOBACCO IN PAST BUT NO LONGER **(YEAR QUIT:_______________)** _______ YES (IF YES, CHECK WHICH ONE BELOW AND HOW OFTEN USED)				
	CIGARETTES/CIGARS		E-CIGARETTES		TOBACCO (chewing,snuff,etc)
PACK(S)/DAY:		HOW OFTEN:		HOW OFTEN:	

Alcohol USE ___NO; ___ YES ________ (drinks/week) Recreational Drugs ___NO; ____YES_____________ (type/how often)

Type of Alcohol : ___________________________________

FAMILY HISTORY: Please check medical problems immediate family members have or have had in the past.

		Mother's Parents			Father's Parents			
MEDICAL CONDITION	**MOTHER**	**GRAND MOTHER**	**GRAND FATHER**	**FATHER**	**GRAND MOTHER**	**GRAND FATHER**	**BROTHER**	**SISTER**
Heart Attack								
Diabetes								
Cancer(Type)_(list):__________								
Stroke								
High Blood Pressure								
High Cholesterol								
Congestive Heart Failure								
COPD/Asthma								
Thyroid Disease								

YOUR MEDICAL HISTORY: IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS PLEASE WRITE IN YEAR DIAGNOSED

	MEDICAL PROBLEM	YEAR		MEDICAL PROBLEM	YEAR		MEDICAL PROBLEM	YEAR
	ANEMIA			ARTHRITIS			ASTHMA	
	ANXIETY			CHRONIC KIDNEY DISEASE			DIABETES	
	DEPRESSION			HIGH BLOOD PRESSURE			HIGH CHOLESTEROL	
	OTHER MENTAL ILLNESS (list):			CANCER TYPE:			MIGRAINES	
	CORONARY ARTERY DISEASE			DEMENTIA			HEADACHES	
	CONGESTIVE HEART FAILURE			HEART ATTACK			GERD/ REFLUX	
	COPD (Chronic Obstructive Pulmonary Disease)			HEART ARRHYTHMIAS (Atrial Fibrillation)			PERIPHERAL VASCULAR DISEASE (PVD)	
	LIVER DISORDERS			STROKE			OSTEOPOROSIS	
	EPILEPSY/SEIZURES			THYROID ISSUES			CROHNS DISEASE	
	ALCOHOL ABUSE PROBLEMS			TUBERCULOSIS HISTORY			HIV	
	DRUG ABUSE PROBLEMS			Other List:			Other List:	

SPECIALIST YOU SEE: LIST NAME BELOW

SPECIALIST NAME	TYPE OF DOCTOR	SPECIALIST NAME	TYPE OF DOCTOR

Do you see any VA (Veteran's Affair) Doctors : ________ YES; ________ NO - Name:____________________________

NAME: ____ DOB: _________________________________

SURGICAL HISTORY: LIST TYPE OF SURGERY AND YEAR: (FEMALES – PLEASE INCLUDE GYN SURGICAL HISTORY)

TYPE OF PROCEDURE/SURGERY	YEAR	TYPE OF PROCEDURE/SURGERY	YEAR

TRAVEL HISTORY OUTSIDE USA(LAST 6 MONTHS) : WHERE AND WHEN_______________________________________

MEDICATION & FOOD ALLERGIES AND TYPE OF REACTION: IF NONE PLEASE WRITE NONE IN BOX BELOW

NAME OF MEDICATION OR FOOD	TYPE OF REACTION	NAME OF MEDICATION OR FOOD	TYPE OF REACTION

LIST OF MEDICATIONS: PRESCRIPTIONS, OVER-THE-COUNTER & HERBAL (MORE THAN 10 PLEASE PROVIDE LIST)

MEDICATION NAME	STRENGTH	DIRECTIONS	REASON YOU TAKE
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

IMMUNIZATION : (IF YOU HAVE VACCINE RECORD PLEASE GIVE US A COPY) (List Month/Day/year)

IMMUNIZATION:	PNEUMOCOCCAL 23 (PNEUMOVAX)	PREVNAR 13	TETANUS (TDAP) or (Td)	Zostravax (Shingles)	INFLUENZA (FLU VACCINE)
DATE VACCINE LAST ADMINISTERED					

Other Immunizations: ____

PREVENTIVE HISTORY: (IF ANY TEST DONE, PLEASE LIST LAST YEAR DONE)

TEST	DATE DONE	TEST	DATE DONE	TEST	DATE DONE
COLONOSCOPY		EYE EXAM; NAME OF EYE DOCTOR		PSA LEVEL (MALES ONLY)	
GUIAC STOOL CARD		PROSTATE EXAM (MALES ONLY)		EKG/STRESS TEST	

FEMALES ONLY: # OF PREGNANCIES : ___________ # OF BIRTHS : ____________ # OF MISCARRIAGES : _________

DO YOU SEE A GYNECOLOGIST: _______ NO ; _______YES (IF YES, DR'S NAME: ____)

DATE OF LAST PAP: ___________________ DATE OF LAST MENSTRAL CYCLE : ____________________

DATE OF LAST MAMMOGRAM : __________________DATE OF LAST BONE DENSITY (DEXA) TEST: ___________________