THE UNIVERSITY OF KANSAS PHYSICIANS

Department of Internal Medicine – General & Geriatric Medicine

Welcome to our practice. Please complete the following health history before you see your physician.

Name _____ **Birthdate** _____ **Date** _____
Age _____ **Gender** □ Male □ Female
Date of Last Tetanus/Tdap shot _____ Last Flu shot _____ Last Pneumonia shot _____
Date of Last Shingles vaccine _____ Last HPV vaccine _____ Last dilated Eye exam _____
Date of Last Mammogram (F) _____ Last pap smear (F) _____→ Results _____
Date of Last Rectal exam _____ Last Cholesterol test _____→ Results _____
Date of Last Colonoscopy _____→ Location _____→ Results _____

Reason for visit: (current symptoms)

1. _____
2. _____
3. _____

Past Medical History: Please mark if you have **ever had**:

	Yes		Yes		Yes
Alcoholism		Colon Cancer		Ovarian Cancer (Female)	
Allergies (Seasonal, Environmental)		Depression		Prostate Cancer (Male)	
Asthma		Diabetes		Respiratory Disease (e.g. COPD)	
Anemia		Heart attack or bypass surgery		Seizure Disorder	
Anxiety disorder		Heart disease		Sexually Transmitted Infection	
Arthritis		High Blood Pressure		Skin Cancer	
Birth Defects		High Cholesterol		Stomach Ulcer	
Blood Clots		Kidney Disease		Stroke	
Blood Transfusion		Lung Cancer		Thyroid Disorder	
Breast Cancer		Osteoporosis		Tobacco Use	
Cervical Cancer (Female)		Other Cancer			
Appendectomy (appendix removal)		Cholecystectomy (gallbladder removal)			

Family History: Please indicate the relationship of the family member who has had any of the following: (e.g. father, sister, grandparent)

	Who		Who		Who
Blood Clots		Diabetes		Prostate Cancer	
Breast Cancer		Heart Disease		Stroke	
Colon Cancer		Osteoporosis			
Depression		Ovarian Cancer			

Father: Age (if living) _____ Age at Death (If Deceased) _____ Cause of death: _____
Mother: Age (if living) _____ Age at Death (If Deceased) _____ Cause of death: _____
Sibling: Age (if living) _____ Age at Death (If Deceased) _____ Cause of death: _____
Sibling: Age (if living) _____ Age at Death (If Deceased) _____ Cause of death: _____
Sibling: Age (if living) _____ Age at Death (If Deceased) _____ Cause of death: _____

Social History:

Marital Status: □ Married □ Single □ Divorced □ Widowed Number of children: _____
Tobacco Use: □ Current □ Previous: began in year _____ quit in year _____ □ Never
Alcohol Use: □ Current □ Previous: began in year _____ quit in year _____ □ Never
Approximate number of alcoholic drinks per day _____ per week _____ per month _____
Exercise: → Number of sessions per week ___ Type _____
Do you have an Advanced Directive: □ Yes □ No Does this office have a copy? □ Yes □ No
Do you have a Durable Power of Attorney or Guardian: □ Yes □ No

Allergies: Please list any allergies to medications or foods. Examples of reactions: Rash or hives, trouble breathing, nausea

Name	Reaction	Name	Reaction
1		5	
2		6	

Medications (prescription & over-the-counter), Herbal Medications, and Supplements: You may attach a typed list of medications instead.

Name	Dose & Frequency	Name	Dose & Frequency
1		6	
2		7	
3		8	
4		9	
5		10	

Review of Systems: Please mark if you have had any of the following symptoms **in the last 3 months**:

CONSTITUTION	X	EYES	X	RESPIRATORY	X	SKIN	X
Appetite loss		Blurred vision		Cough		Changes in nail beds	
Chills		Discharge		Coughing up blood (Hemoptysis)		Discoloration	
Diaphoresis (Sweating)		Double vision		Shortness of breath		Dryness	
Fever		Pain		Sleep disturbances due to breathing		Flushing	
Generalized weakness		Sensitivity to light (Photophobia)		Snoring		Itching	
Fatigue (Malaise)		Redness		Sputum production		Poor wound healing	
Night sweats		Vision loss – left		Wheezing		Rash	
Weight gain		Vision loss - right		**ENDOCRINE**	**X**	Skin cancer	
Weight loss		Visual disturbance		Cold intolerance		Suspicious lesions	
HEAD/ENT	**X**	Visual halos		Heat intolerance		Unusual hair distribution	
Congestion		**CARDIOVASCULAR**	**X**	Excessive thirst (Polydipsia)		**MUSCULOSKELETAL**	**X**
Ear discharge		Chest pain		Increased appetite (Polyphagia)		Arthritis	
Ear pain		Pain in legs with walking (Claudication)		Excessive urination volume (Polyuria)		Back pain	
Headaches		Blue skin or nails (Cyanosis)		**HEMATOLOGIC**	**X**	Falls	
Hearing loss		Shortness of breath (Dyspnea) on exertion		Enlarged lymph node (Adenopathy)		Gout	
Hoarseness		Irregular heartbeats		Bleeding		Joint pain	
Nosebleeds		Leg swelling		Bruises/bleeds easily		Joint swelling	
Painful swallowing (Odynophagia)		Near-fainting (Syncope)		**NEUROLOGICAL**	**X**	Muscle cramps	
Sore throat		Shortness of breath lying flat (Orthopnea)		Loss of voice (Aphonia)		Muscle weakness	
Inhale wheeze (Stridor)		Palpitations		Brief paralysis		Muscle pain (Myalgias)	
Ringing in ear (Tinnitus)		Waking up short of breath at night (PND)		Concentration difficulty		Neck pain	
GASTROINTESTINAL	**X**	Fainting (Syncope)		Coordination disturbances		Stiffness	
Abdominal bloating		**GENITOURINARY**	**X**	Daytime sleepiness		**PSYCHIATRIC**	**X**
Abdominal pain		Bladder incontinence		Dizziness		Altered mental status	
Anorexia		Decreased libido		Focal weakness		Depression	
Bowel habits change		Painful urination (Dysuria)		Light-headedness		Hallucinations	
Bowel incontinence		Flank pain		Loss of balance		Abnormally increased state of awareness (Hypervigilance)	
Constipation		Frequency		Numbness		Trouble sleeping (Insomnia)	
Diarrhea		Genital sore		Prickling or tingling sensation (Paresthesias)		Memory loss	
Trouble swallowing (Dysphagia)		Blood in urine (Hematuria)		Seizures		Nervous/Anxious	
Excessive appetite		Hesitancy		Sensory change		Substance abuse	
Gas (Flatus)		Incomplete bladder emptying		Tremors		Suicidal thoughs	
Heartburn		Heavy periods (Menorrhagia)		Vertigo		Thoughts of violence	
Throwing up blood (Hematemesis)		Missed period (Menses)				**ALLERGY/IMMUNOLOGY**	**X**
Fresh blood in stools (Hematochezia)		Night-time urination (Nocturia)				Environmental allergies	
Hemorrhoids		Non-menstrual vaginal bleeding				HIV exposure	
Yellow eyes or skin (Jaundice)		Pelvic pain				Hives	
Black tarry stools (Melena)		Urgency of urination				Persistent infections	
Nausea							
Vomiting							