Roswell Internal Medicine Specialists, P.C.

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PERSONAL INFORMATION

Name: ____________________________________ **Date:** ______________________________

Date of Birth: _____________ **Age:** _____ **Sex:** ________ **Marital Status:** ______________

Occupation: ____

MEDICAL HISTORY

Current Medications: ____

____

____

____

Current Health Problems**:**

____

____

____

Previous Health Problems:

____

____

ALLERGIES

MEDICATION	OTHER THAN MEDICATION

HOSPITALIZATIONS

	Description	Year	Hospital
Illness: (kind)			
Surgery: (kind)			
Other: (reason)			

FAMILY HISTORY

	Living	Deceased	If deceased, please list cause.
Father	•	•	______
Mother	•	•	______
Sibling's	•	•	______
	•	•	______
	•	•	______
	•	•	______
	•	•	______
Children	•	•	______
	•	•	______
	•	•	______

Is there any family history of:

	Yes	No	Who?		Yes	No	Who?
Heart Disease	•	•	______	Stroke	•	•	______
Hypertension	•	•	______	Cancer	•	•	______
Mental Disorder	•	•	______	Alcoholism	•	•	______
Diabetes	•	•	______	Kidney Disease	•	•	______
Breast Cancer	•	•	______				

PERSONAL HABITS

	Yes	No	If yes, how much/how often?
Do you smoke?	•	•	______
Do you chew Tobacco?	•	•	______
Do you drink alcohol?	•	•	______
Do you use drugs?	•	•	______
Do you exercise regularly?	•	•	______

FOR WOMEN ONLY

Menstrual Periods? ______
Age Onset ______
Date of last Period ______
Difficulty with periods ______
Specify ______
Age of menopause ______
Lumps or discharge from breasts? Yes • No •

Pregnancies: ______
Live Births ______ Caesarian ______
Premature ______ Miscarriages ______
Do you use birth control pills______
Do you practice self breast examinations? ______
Date of last PAP smear: ______
Date of last mammogram: ______

PATIENT MEDICAL HISTORY

Please check NO or YES as applicable. If yes, give a brief description of problem.

NO		YES
( )	Weight Change	( )
( )	Appetite change	( )
( )	Fever / Chills	( )
( )	Night Sweats	( )
( )	General weakness	( )
( )	Dizziness, whirling or feeling faint	( )

ENDOCRINE SYSTEM

NO		YES
( )	Heat or cold intolerance	( )
( )	Thyroid problems	( )
( )	History of neck surgery	( )
	or irradiation	( )
( )	Increase in thirst	( )
( )	Increase in urination	( )

EYES

NO		YES
( )	Failing vision / blind	( )
( )	Cataracts	( )
( )	Double vision	( )
( )	Pain	( )
( )	Glasses	( )

EARS, NOSE, THROAT

NO		YES
( )	Difficulty hearing / deaf	( )
( )	Ringing in ears	( )
( )	Nose bleed	( )
( )	Hoarseness	( )
( )	Sinusitis	( )

GASTROINTESTINAL SYSTEM

NO		YES
( )	Nausea	( )
( )	Vomiting	( )
( )	Vomiting blood	( )
( )	Difficulty in swallowing	( )
( )	Indigestion / Heartburn	( )
( )	Abdominal pain	( )
( )	Abdominal swelling	( )
( )	Jaundice	( )
( )	Red blood in stool	( )

NO		YES
( )	Black stool	( )
( )	Inability to control stool	( )
( )	Diarrhea	( )
( )	Constipation	( )
( )	Hemorrhoids	( )
( )	Hernia	( )
( )	Ulcer Disease History	( )
( )	Gall Bladder Disease History	( )
( )	Pancreatitis history	( )

LUNG

NO		YES
( )	Shortness of breath	( )
( )	Shortness of breath on exertion	
( )	Sit up to breathe	( )
( )	Get up after going to sleep to get get breath	
( )	Cough now? How long?	( )
( )	Phlegm: volume, color, odor, viscosity	( ).
( )	Cough blood	( )
( )	Wheezing	( )
( )	Blueness in the lip or fingertips	( )
( )	Asthma history	( )
( )	Pneumonia history	( )
( )	History of tuberculosis or exposure to tuberculosis	( )
( )	Skin test for tuberculosis Positive or Negative (circle)	( )
( )	Chest x-ray in last year	( )
( )	History of Respiratory infections, give frequency	( )

HEART AND BLOOD VESSELS

NO		YES
( )	Chest Discomfort	( )
( )	Fainting spells	( )
( )	Palpitations	( )
( )	Swelling of ankles	( )
( )	Pain in legs, calves, or feet while walking	( )
( )	Swelling or pain in calves	( )
( )	Hypertension history	( )
( )	Heart murmur	( )
( )	Rheumatic Fever	( )

PATIENT MEDICAL HISTORY (Page 2)

GU SYSTEM (GENERAL)

NO		YES
( )	Frequency passing urine	( )
( )	Urgency in passing urine	( )
( )	Pain in passing urine	( )
( )	Abnormal urine color	( )
( )	Blood in urine	( )

MALE GENITALIA

NO		YES
( )	Stream size & force decreased	( )
( )	Hesitancy	( )
( )	Inability to hold urine (stress, urge, dribbling) of urine	( )
( )	History of renal disease or stones	( )

FEMALE GENITALIA

Last menstrual period: ______________________________

NERVOUS SYSTEM

NO		YES
( )	Headaches	( )
( )	Loss of consciousness	( )
( )	Seizures	( )
( )	Stroke history	( )

BLOOD

NO		YES
( )	Abnormal bleeding / bruising	( )
( )	Anemia	( )
( )	Transfusions	( )
( )	Family history of Sickle Cell	( )

MUSCULOSKELETAL SYSTEM

NO		YES
( )	Joint stiffness	( )
( )	Joint pain	( )
( )	Joint swelling	( )
( )	Muscle weakness	( )
( )	Backache	( )

Patient name: ______________________________

Date: ______________________________

Patient Profile

Name: ______________________ Patient ID# __________ Sex: __________

Address: ______________________ Date of Birth: ______________________

City, State: ______________________ Marital Status: ______________________

Phone: ________________( ) Home ( )Work ( )Other Referring Physician: ______________________

Phone: ________________( ) Home ( ) Work ( ) Other Primary Physician: ______________________

PATIENT EMPLOYMENT

( ) Employed ( ) Retired ( ) Other

Phone: ______________________

Employer: ______________________

CONTACTS

____

____

____

GUARANTOR

( ) Same as Patient

Name: ______________________

Address: ______________________

____

City, State: ______________________

EMPLOYMENT

Employer: ______________________

Phone: ______________________

Phone: ______________________

Social Security: ______________________

Date of Birth: ______________________

PRIMARY INSURANCE

( ) Same as Patient ( ) Same as Guarantor ( ) Other

Insured Party: ______________________ Social Security #: ______________________

Relationship to Patient: ______________________ Insured ID: ______________________

Insured Phone: ______________________ Policy Group: ______________________

Company: ______________________ Date of Birth: ______________________

SECONDARY INSURANCE

( ) Same as Patient ( ) Same as Guarantor ( ) Other

Insured Party: ______________________ Social Security #: ______________________

Relationship to Patient: ______________________ Insured ID: ______________________

Insured Phone: ______________________ Policy Group: ______________________

Company: ______________________ Date of Birth: ______________________