ROSWELL INTERNAL MEDICINE SPECIALISTS
Dr. Gorka Zurinaga, M.D.
11785 Northfall Lane, Suites 505 & 506, Alpharetta, GA 30009
p: (678) 393-0012 • f: (678) 393-5158

English - Spanish

PATIENT MEDICAL HISTORY (PART 1)

Full Name (Print): _____

Date of Birth: _____ Today's Date: _____

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

☐ Heat or Cold Intolerance	☐
☐ Thyroid Problems	☐
☐ History of Neck Surgery or irradiation	☐
☐ Increase in Thirst	☐
☐ Increase in Urination	☐

EYES

☐ Failing Vision/ Blind	☐
☐ Cataracts	☐
☐ Double Vision	☐
☐ Pain	☐
☐ Glasses	☐

EAR, NOSE, THROAT

☐ Difficulty Hearing/Deaf	☐
☐ Ringing in Ears	☐
☐ Nose Bleed	☐
☐ Hoarseness	☐
☐ Sinusitis	☐

GASTROINTESTINAL SYSTEM

☐ 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

☐ Shortness of Breath	☐
☐ Shortness of Breath on Exertion	☐
☐ Sit up to Breathe	☐
☐ Get up after going to sleep To 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	☐
☐ Skilll Test for Tuberculosis Positive ☐ Negative ☐	☐
☐ Chest X-Ray in last year	☐
☐ History of Respiratory Infections, give frequency	☐

HEART & BLOOD VESSELS

☐ Chest Discomfort	☐
☐ Fainting Spells	☐
☐ Palpitations	☐
☐ Swelling of Ankles	☐
☐ Pain in Legs, Calves, or Feet While walking	☐
☐ Swelling or Pain in Calves	☐

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PATIENT MEDICAL HISTORY (PART 1)

PATIENT MEDICAL HISTORY (PART 2)

HEART & BLOOD VESSELS (continued)

NO	YES
☐ Hypertension History	☐
☐ Heart Murmur	☐
☐ Rheumatic Fever	☐

GU SYSTEM (GENERAL)

☐ Frequency passing Urine	☐
☐ Urgency in passing Urine	☐
☐ Pain in passing Urine	☐
☐ Abnormal Urine Color	☐
☐ Blood in Urine	☐

MALE GENITALIA

☐ Stream Size & Force decreased	☐
☐ Hesitancy	☐
☐ Inability to hold Urine (Stress, Urge, Dribbling) of Urine	☐
☐ History of Renal Disease or Stones	☐
☐ History of STD's	☐

FEMALE GENITALIA

☐ Vaginal Bleeding (not Menstrual)	☐
☐ History of STD's	☐

Last Menstrual Period: _____

NERVOUS SYSTEM

NO	YES
☐ Headaches	☐
☐ Loss of Consciousness	☐
☐ Seizures	☐
☐ Stroke History	☐

BLOOD

☐ Abnormal Bleeding / Bruising	☐
☐ Anemia	☐
☐ Transfusions	☐
☐ Family History of Sickle Cell	☐

HEART & BLOOD VESSELS

☐ Joint Stiffness	☐
☐ Joint Pain	☐
☐ Joint Swelling	☐
☐ Muscle Weakness	☐
☐ Backache	☐
☐ NeckPain	☐

PATIENT MEDICAL HISTORY (PART 2)

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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) _____

_____

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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?	❑	❑	

HAVE YOU HAD ANY
Dexa Scan _____
Colonoscopy _____
Endoscopy _____

FOR WOMEN ONLY

Menstrual Periods _____
Age Onset _____
Date Of Last Period _____
Difficulty With Periods _____
Specify _____

Pregnancies _____
Live Births _____ Caesarian _____
Premature _____ Miscarriages _____
Date of last PAP Smear _____
Age of menopause _____

Do you use birth control pills? _____
Do you practice self breast examinations? _____
Lumps or discharge from breasts? _____
Date of last mammogram _____

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FAMILY HISTORY