WILMINGTON INTERNAL MEDICINE

Patient History Form

CURRENT MEDICATIONS

Medication name	Dosage	Frequency

DATE _____ CHART # _____

NAME _____

HM PH _____ WK PH _____

DOB _____ AGE _____

SS# _____

ALLERGIES _____

_____

Do you take: ❑ Multivitamin ❑ Calcium ❑ Aspirin a day ❑ Extra Vitamin E ❑ Herbal Remedies

CURRENT/PAST ILLNESSES ?WHEN

(Ex. Asthma, Arthritis, Diabetes, Cholesterol, High Blood Pressure, Heart Disease, Thyroid Problems, Hysterectomy, Anemia, Back Surgeries)

HOSPITALIZATIONS/SURGERIES ?WHEN

FAMILY HISTORY: WHAT ILLNESSES HAVE YOUR FAMILY MEMBERS HAD?

(Ex. Colon Cancer, Heart Attack, Stroke, Kidney Disease, Alzheimers, Cancer, High Blood Pressure, High Cholesterol, Glaucoma, Diabetes)

	AGE	ILLNESS		AGE	ILLNESS
Mother	_____	_____	Father	_____	_____
Grand-Parents	_____	_____	Grand-Parents	_____	_____
Siblings	_____	_____	Siblings	_____	_____
Children	_____	_____	Children	_____	_____

SOCIAL HISTORY (check all that apply)

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Alcohol? Type _____ Amount _____ Ever use street drugs? Y / N Carry a weapon? Y / N

Caffeine? Type _____ Amount _____ How often do you exercise? _____

Smoke? Packs/day _____ For How Long? _____ Interested in quitting? Y / N Quit _____ yrs

Exposed to: ❑ Solvents ❑ Fumes ❑ Airborne particles ❑ Asbestos

Fat intake: ❑ Mild ❑ Moderate ❑ Unrestricted Do you wear your seat belt? Y / N

Salt intake: ❑ Mild ❑ Moderate ❑ Unrestricted

Do you have: ❑ Difficulty falling asleep? ❑ Frequent wakening? ❑ Snoring?

Are you satisfied with your quality of **Health and Well-Being**? ❑ Yes ❑ No ❑ Somewhat

What kind of work do you do? _____ Last Colonoscopy _____

When was your last (some may not apply):

Cholesterol Screen _____ Tetanus Booster _____ Pap Smear _____

Flu Vaccine _____ Rectal Exam _____ Mammogram _____

HGA1C (diabetics) _____ Bone Density _____ PSA Prostate Screen _____

What other doctors do you see? _____