CONSULTANTS IN INTERNAL MEDICINE
Patient Data Sheet

Name ______________________________ Date of Birth ________________ Date _________

Physician ___________________________ Insurance _____________________________

A. Past Medical and Surgical History Dates

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

B. Medications

Name of medication	Dosage	How many times daily?	How long have you been taking it?

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

C. Medication allergies

Name of Medication | What was the reaction to medication

1. ____
2. ____
3. ____
4. ____
5. ____

D. Immunizations--Dates

Flu ____________ Pneumonia _________ Zostavax/Shingles ________ Tetanus ____________

E. Family History

Medical issues (Hypertension, heart disease, stroke, cancer, asthma, diabetes, etc.)

Father ____

Mother ____

Siblings ____

Children ____

Grandparents ____

F. Social History

Do you have a Living Will or Power of Attorney? yes______no ____

Do you smoke? yes ______no _____ If yes, how many per day? _____

What age did you start smoking? _____

If you quit, how long did you smoke? _____how many per day? ______year quit? _____

How much alcohol do you drink ____ __daily __weekly? which type? _______

Any prior history of alcohol abuse? ______

Any prior history of drug abuse? _____

What kind of work do you do? ____________

If retired, what kind of work did you do? ___________

Do you have a history of depression? ___ Any related hospitalizations? ___When? _____

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G. Review of Systems

Please check for symptoms you have frequently

HEAD:
__Headaches
__Lightheaded/dizziness
__Seizures/Epilepsy

EYES:
__Glasses
__Blurring of vision
__Pain in eyes
__Discharge
__Spots or ragged lines
__Flashes of light

ENT:
__Ringing in ears
__Hearing loss
__Hoarseness
__Postnasal drip
__Nose bleeds
__Sinus pain

CHEST:
__Frequent cough
__Coughing up blood
__Pleurisy
__Wheezing
__Chest pain
__Palpitation
__Shortness of breath

KIDNEYS:
__Kidney Stones
__Infections
__Burning on urination
__Blood in urine
__Frequency

SKIN:
__Changing skin lesions
__Acne
__Rash

CIRCULATION:
__Ankle swelling
__Varicose veins
__Numbness

GASTROINTESTINAL:
__Heartburn
__Trouble swallowing
__Bloody or black stools
__Hemorrhoids
__Constipation
__Diarrhea
__Nausea/vomiting

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Patient Data Sheet

FOR MEN ONLY:

__Pain or lumps in testes

__Difficulty with erections

__Slow urinary stream

FOR WOMEN ONLY:

_____ Last Menstrual Period

_____ Date of last Mammogram

_____ Date of last Pap smear

_____ Number of pregnancies/live births

_____ Age menstruation began

__Pain with intercourse

__Bleeding between periods/irregular periods

__Perform self-breast exam

__Discharge

_History of abnormal Pap smear