

DUBUQUE INTERNAL MEDICINE

CURRENT HISTORY SHEET

Please take a few moments to fill out the following questionnaire. We will use this information as part of our continual efforts to provide you with the best health care. All the information you provide will become part of your medical record and is therefore kept **strictly confidential**. Please answer these questions to the best of your ability, leaving blank those questions for which you are unsure of the answer.

NAME _____

DATE OF BIRTH: _____

HOME PHONE (____) _____ - _____

WORK PHONE: (____) _____ - _____

TODAY'S DATE: _____

REASON FOR VISIT TODAY: _____

MEDICAL HISTORY:

➤ **SURGICAL/HOSPITALIZATION HISTORY** (Please list, excluding pregnancies): _____

➤ **MEDICAL HISTORY** (Please list ALL CURRENT medical problems and date started. For example, high blood pressure, 1973): _____

➤ **MEDICATIONS** (Please make a habit of bringing ***all*** your medicines including non-prescription medicines and vitamin/mineral/herbal supplements to ***every*** visit to the office)

<u>Name of medicine</u>	<u>Strength (mg)/frequency</u>	<u>Name of medicine</u>	<u>Strength(mg)/frequency</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

➤ **ALLERGIES/ ADVERSE REACTIONS** (Please list any medications to which you have had an allergic reaction. Include medications you have taken that have adverse side effects. List any foods or other products you are allergic to as well.) _____

HEALTH HABITS: (Please list your smoking history, alcohol use and any drug use): _____

SYSTEM REVIEW Please indicate whether you have experienced any of symptoms (by CIRCLING) in the following areas *over the last several months*. Please use the additional space for further comments if you wish.

1. Constitutional symptoms such as fever, significant weight loss
or weight gain, night sweats: _____
2. Any symptoms in Eyes, Ears, Nose, Mouth and Throat: _____
3. Any symptoms in Heart, Lungs, Stomach or Bowels: _____
4. Any symptoms in Urinary system, Genitals or Breasts: _____
5. Any symptoms in Joints, Muscles or skin: _____
6. Any symptoms in nervous system/psychiatric problems: _____
7. Any other symptoms not addressed above: _____

PREVENTIVE MEDICINE: Please CIRCLE the following preventive medicine measures if you have had any of them within the time frame specified:

COLON CANCER SCREEN (if ≥ 50 y/o): fecal occult blood testing in last yr; flexible sigmoidoscopy in last 5 yrs; colonoscopy in last 10 years.

BREAST CANCER SCREENING (if ≥ 50 y/o): Mammogram in last year;

CERVICAL CANCER SCREENING: Pap smear within the last three years;

PROSTATE CANCER SCREENING (if ≥ 50 y/o): PSA in the last year; rectal exam of prostate in the last year;

HEART DISEASE PREVENTION: Cholesterol checked in last 5 years; taking aspirin daily if ≥ 50 y/o.

IMMUNIZATIONS: Tetanus booster in last 10 years; Influenza vaccine in last year (if ≥ 65 y/o); Pneumococcal vaccine (if > 65 y/o) within last 6 yrs; Hepatitis B series (3 shots) ever; Measles vaccine if born after 1957.

FAMILY HISTORY: Many diseases run in families. Please list any family members with medical problems including parents, grandparents, brothers and sisters. For example, Mother -66 y/o now, had breast cancer when 47 y/o; Brother 46 y/o, heart attack, died.

ADVANCED DIRECTIVES

In the event that you are unable to express your wishes for certain medical interventions in the future, you should consider a “Living Will” or “Power of Attorney” or both.

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| | | I have one | I don't have one | I want more information |
| ➤ | <u>LIVING WILL</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ | <u>POWER OF ATTORNEY</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Reviewed and <u>Annotated (list # and comments below)</u> by		
Signature	Date	Any changes/comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____