A. S. KERPE, M.D. INTERNIST

PATIENT/FAMILY MEDICAL HISTORY

Name: _____ Date Form Completed: _____

Address: _____

Phone: _____ Work Phone: _____ DOB: _____

Reason for seeing the doctor today: _____

_____

Please list major hospitalizations including surgery. (Do not list pregnancy unless you had a Cesarean Section or complications.)

Year	Place	Illness/Operation	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST MEDICAL HISTORY: Please check which of the following problems you have had, and if possible, indicate the year:

Yes	**Year**	**Yes**	**Year**
( ) Heart Disease	_____	( ) Tuberculosis	_____
( ) Diabetes	_____	( ) Seizure/Epilepsy	_____
( ) High Blood Pressure	_____	( ) Allergy	_____
( ) Cancer	_____	( ) Rheumatic Heart Disease	_____
Please specify organ: _____		( ) Liver Disease	_____
( ) Lung Disease	_____	( ) Other (Specify):_____	

Drug Allergy/Intolerance: ( ) Yes ( ) No If yes, give name of drug(s): _____

IMMUNIZATIONS: Please check if YES

Rubella (German Measles): ____ Typhoid: ____ Diphtheria: ____ Polio: ____ Whooping Cough (Pertussis): ____
Tetanus: ____ Date of last tetanus: ____

Please list the MEDICATIONS you are currently taking (including birth control pills):

Name of Medication:	Dosage:	Date Started:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Please continue to the back side of this form)

PATIENT SOCIAL HISTORY:
Marital Status: _____ Education (highest level completed):_____
Place of Birth: _____ Occupation: _____

HABITS
Coffee/Tea ( ) Yes ( ) No How many cups her day?_____
Tobacco ( ) Yes ( ) No If yes, number of packs per day? _____ How many years? _____
Alcohol ( ) Yes ( ) No How much in a usual week (drinks or bottles of beer)?_____
Sleep: Approximately how many hours per night? _____

FAMILY HISTORY: Please list the following information about your family:

Age	**Major Illness**	**Living/Deceased**	**If Deceased, at what age?**
Father			
_____	_____	_____	_____
Mother			
_____	_____	_____	_____
Brothers/Sisters			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Children			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REVIEW OF SYSTEMS: Have you had any of the following? Please check if YES.

HEENT: Headaches ( ) Earaches ( ) Difficulty Swallowing ( ) Dizziness ( )
Hearing Problems ( ) Hoarseness ( ) Visual Changes ( ) Seizures ( ) Sinus Problems ( )

RESP: Shortness of Breath ( ) Difficulty Breathing ( ) Chronic Cough ( )

CV: Palpitations ( ) Chest discomfort ( ) Swelling of legs ( ) Aching in calves w/ exertion ( )

GI: Nausea ( ) Vomiting ( ) Heartburn ( ) Constipation ( ) Change in bowel habits ( )
Blood or blackness in stools ( ) Night voiding ( ) Burning on urination ( )

MENSTRUAL: Pregnancies # ( ) Live Births # ( ) Miscarriages # ( )
First period age ( ) Problems? _____
Date of last period:_____ Date of last Pelvic/Pap Smear:_____
Abortions # ( ) Abnormal vaginal bleeding?_____

EXTREMITIES: Arthritis ( ) Joint Pain ( ) Swelling ( ) Back pain ( )
MISC: Fever ( ) Fatigue ( ) Sweating ( ) Weight Loss/Gain ( ) Chills ( ) Nervousness ( )

Additional Comments: