

# INTERNAL MEDICINE ASSOCIATES OF TEXAS

## Medical Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

### Past Medical History:

Check (✓) conditions you have or have had in the past.

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Depression          | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Back Problems      | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> HIV Positive        | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Transfusion  | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Polio              |   |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Kidney Stone        | <input type="checkbox"/> Prostate Problem   |   |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Rheumatic Fever    |   |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Measles             | <input type="checkbox"/> Scarlet Fever      |   |

Past Surgical History: \_\_\_\_\_

Hospitalization Other Than Surgery: \_\_\_\_\_

### Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies to Medications, X-Ray Dyes, or Other Substances  No  Yes  
(If yes, please list name of medicine and type of reaction)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family History: Has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness	Which family member?	Age when diagnosed
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression, etc.)	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____
Other	_____	_____

### Immunization history — Have you had?

Hepatitis B Vaccine  No  Yes When? \_\_\_\_\_  
Hepatitis A Vaccine  No  Yes When? \_\_\_\_\_  
Pneumovax immunization?  No  Yes When? \_\_\_\_\_  
Tetanus immunization?  No  Yes When? \_\_\_\_\_

**Review of Systems:** Check (✓) symptoms you currently have or have had in the past year.

<p><b>General</b></p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Depression/Nervousness</p> <p><input type="checkbox"/> Dizziness/Fainting</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Forgetfulness</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Sweats</p> <p><b>Muscle/Joint/Bone</b></p> <p>Pain, weakness, numbness in:</p> <p><input type="checkbox"/> Arms</p> <p><input type="checkbox"/> Back</p> <p><input type="checkbox"/> Feet</p> <p><input type="checkbox"/> Hands</p> <p><input type="checkbox"/> Hips</p> <p><input type="checkbox"/> Legs</p> <p><input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Shoulders</p> <p><b>Genito-Urinary</b></p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Lack of bladder control</p> <p><input type="checkbox"/> Painful urination</p>	<p><b>Gastrointestinal</b></p> <p><input type="checkbox"/> Appetite poor</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Bowel changes</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Rectal bleeding</p> <p><input type="checkbox"/> Stomach pain</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Vomiting blood</p> <p><b>Cardiovascular</b></p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> High/Low blood pressure</p> <p><input type="checkbox"/> Irregular/Rapid heart beat</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Swelling of ankles</p> <p><input type="checkbox"/> Varicose veins</p> <p><b>Eye, Ear, Nose, Throat</b></p> <p><input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Crossed eyes</p> <p><input type="checkbox"/> Difficulty swallowing</p>	<p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Earache/Ear discharge</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Persistent cough</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Vision - Flashes/Halos</p> <p><b>Skin</b></p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching/Rash</p> <p><input type="checkbox"/> Change in moles</p> <p><input type="checkbox"/> Scars</p> <p><input type="checkbox"/> Sore that won't heal</p> <p><b>MEN only</b></p> <p><input type="checkbox"/> Erection difficulties</p> <p><input type="checkbox"/> Lump in testicles</p> <p><input type="checkbox"/> Penis discharge</p> <p><input type="checkbox"/> Sore on penis</p> <p>Date of last colonoscopy _____</p> <p>Date of last PSA _____</p>	<p><b>WOMEN only</b></p> <p><input type="checkbox"/> Abnormal Pap Smear</p> <p><input type="checkbox"/> Abnormal Vaginal Discharge</p> <p><input type="checkbox"/> Bleeding lump</p> <p><input type="checkbox"/> Extreme menstrual pain</p> <p><input type="checkbox"/> Heavy menstrual bleeding</p> <p><input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Nipple discharge</p> <p><input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> Pelvic pain</p> <p><input type="checkbox"/> Vaginal discharge</p> <p><input type="checkbox"/> Other _____</p> <p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Date of last mammogram _____</p> <p>Date of last bone density _____</p> <p>Date of last colonoscopy _____</p> <p>Pregnancies _____</p> <p>Birth _____ Miscarriage _____</p>
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**Prevention**

Do you wear seat belts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, why not? _____
Do you wear a bike helmet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type, duration and number of times per week? _____
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much per week? _____
Do you drink coffee?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many cups per day? _____
Do you drink tea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many cups per day? _____
If there is a gun in your home, do you keep it unloaded and out of children's reach?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain: _____
Do you wish to be tested for AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain: _____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you ever feel afraid of your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you have a "living will"?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a donor card?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Signatures**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative	Date
Please print name of Patient, Parent, Guardian or Personal Representative	Relationship to Patient