GWINNETT INTERNAL MEDICINE ASSOCIATES
MEDICAL HISTORY

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☐ Hamilton Mill Office
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Name _____ DOB _____ Date _____

Marital Status ☐ S ☐ M ☐ W ☐ D Occupation _____

Reason for visit _____

_____

Allergies _____

_____

Review of System *Please circle if you are currently having any of the following*

General
Fever
Chills
Fatigue
Depression
Anxiety
Loss of appetite
Weight loss
Weight gain
Snoring
Sleep disturbance
Daytime sleepiness
Skin lesion

Gastrointestinal
Indigestion
Heartburn
Abdominal pain
Nausea/vomiting
Bloating
Acid reflux
Diarrhea
Constipation
Hemorrhoids
Rectal bleeding
Change in bowel habits

HEENT
Blurred vision
Double vision
Treatment for glaucoma
Glasses (reading/distance)
Hearing loss
Ear discharge
Earache
Wax buildup
Nose bleeds
Post nasal drip
Allergies/sneezing
Chronic sinusitis
Difficulty swallowing
Sore throat
Fever blister
Chronic gum/teeth disease

Musculoskeletal
Joint pain
Backache
Muscle pain
Swollen joints
Gout attacks
Bone pain

Respiratory
Cough
Pleurisy
Wheezing
Bloody phlegm
Shortness of breath

Neurology
Headache
Dizziness
Tingling
Numbness
Memory loss
Muscle weakness
Difficulty in walking

Cardiovascular
Chest pain
Shortness of breath
Heart palpitations
Swollen ankles

GYN
Urine leakage
Pelvic pain
Prolonged bleeding
Abnormal bleeding
Abnormal discharge
Hormone treatment
Menopause
Hot flashes
Loss of libido
Birth control method
Self breast exam

Genitourinary
Frequency
Urgency
Incontinence
Blood in urine
Nighttime frequency
Change in sex drive
Erectile dysfunction
Penile discharge

Medications *Please list all medications you are currently taking; include strength and dosage.*

_____

_____

_____

Past History *Please circle if you had any of the following*

Medical

Arthritis	Asthma	Ulcers	Kidney Disease or Stones	Blood Clots
Diabetes	Pneumonia	Anemia	High Blood Pressure	Migraines
Cancer	Tuberculosis	Colon Polyps	Gallbladder Disease	Gout
Heart Disease	Hay Fever	Liver Disease	Alcohol Abuse	Anxiety
Allergies	Hepatitis	HIV / AIDs	Rheumatic Fever	Thyroid Disease
Depression	Colitis	Skin Disease	Venereal Disease	Blood Disorder

Operations and Hospitalizations

Operations	***Date***	***Hospitalizations***	***Date***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Procedure	***Date***	***Procedure***	***Date***
Lab work _____	_____	Treadmill _____	_____
Dexascan _____	_____	Cardiac Cath _____	_____
Colonoscopy _____	_____	EKG _____	_____
Prostate Exam _____	_____	Pacemaker _____	_____

Immunizations

DateImmunizations	***Date***

Gynecological and Obstetrical	***Date***		***Date***
Onset of Periods _____	_____	Births _____	_____
# of Pregnancies _____	_____	Miscarriages _____	_____
Last Pap Smear _____	_____	Last Mammogram _____	_____

Family History *List age and relationship of any family member who had the following.*

Illness	**Family Member and Age**	**Illness**	**Family Member and Age**
Asthma	_____	Dementia	_____
Bleeding Disease	_____	Heart Disease	_____
Cancer (location)	_____	High Blood Pressure	_____
Diabetes	_____	Mental Disease	_____
Drug or Alcohol Addiction	_____	Strokes	_____

Prevention

Do you drink coffee or tea?	☐Y ☐N	How many cups per day?	_____	Do you wear seatbelts?	☐Y ☐N
Do you drink alcoholic beverages?	☐Y ☐N	How much per week?	_____	Do you have a living will?	☐Y ☐N
Do you smoke?	☐Y ☐N	How many packs per day?	_____	Do you have a donor card?	☐Y ☐N
Do you use drugs?	☐Y ☐N	Explain _____		Are you abused by your partner?	☐Y ☐N
Do you want to be tested for HIV?	☐Y ☐N				

Concerns to be discussed with the physician _____

_____

_____

I give permission to discuss my medical conditions and test/lab results with the following person(s)

_____

_____

Patient Signature _____ Date _____