GWINNETT INTERNAL MEDICINE ASSOCIATES
Primary Care • Geriatric • Women's Wellness

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Annual Medical History

☐ Hamilton Mill Office www.gimamd.com ☐ Lawrenceville Office

Name _____ DOB _____ Date _____

Allergies_____

Past Medical History: Have you been diagnosed with any new illnesses since your initial visit? If yes, explain.

_____

Operations: Have you had any operations or hospitalizations since your initial visit? If yes, explain.

_____

Immunizations: Are you due for any booster shots or vaccinations? If yes, explain.

_____

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

Lifestyle

	Yes	No
Do you have a living will?	____	____
Have you had blood transfusions?	____	____
Do you want to be tested for AIDS?	____	____
Do you exercise regularly?	____	____
Do you smoke or chew tobacco?	____	____
Do you drink alcoholic beverages?	____	____
Do you drink coffee or tea?	____	____