Peace Valley Internal Medicine, P.C. Date: ___________________________

MEDICIAL HISTORY FORM *(Please Print)*

NAME: _______________________________________ DATE OF BIRTH: _______________________________

ADDRESS: ____

HOME #: _______________________ CELL #: _____________________ EMAIL: ________________________

MEDICATIONS: *(Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)*

Drug Name	*Dose*	*Drug Name*	*Dose*

ALLERGIES: ☐ YES ☐ NO KNOWN ALLERGIES

(If yes, please list allergy and type of reaction)

____ ____

____ ____

____ ____

HEALTH MAINTENANCE: *(If yes, please indicate the date.)*

Pneumovax Immunization: ☐ No ☐ Yes M/YR: ____

Flu Immunization: ☐ No ☐ Yes M/YR: ____

Tetanus Immunization: ☐ No ☐ Yes M/YR: ____

Zoster Immunization: ☐ No ☐ Yes M/YR: ____

Stool Check for Blood: ☐ No ☐ Yes M/YR: ____

Cholesterol: ☐ No ☐ Yes M/YR: ____

Hepatitis B: ☐ No ☐ Yes M/YR: ____

Colonoscopy: ☐ No ☐ Yes M/YR: ____

Gender Specific

Gardasil/HPV: ☐ No ☐ Yes M/YR: ____

Pap Smear: ☐ No ☐ Yes M/YR: ____

Breast Exam: ☐ No ☐ Yes M/YR: ____

Dexa Scan: ☐ No ☐ Yes M/YR: ____

Prostate Exam: ☐ No ☐ Yes M/YR: ____

PAST MEDICAL HISTORY:

Please check the conditions you have been diagnosed with or are presently experiencing of the following:

✓		Yr of onset	✓		Yr of onset	✓		Yr of onset
	Anemia			Coronary Artery Disease			Migraine Headaches	
	Angina			Crohn's Disease			Myocardial Infarction	
	Anxiety			Depression			Osteoarthritis	
	Arthritis			Diabetes			Peptic Ulcer Disease	
	Asthma			Gallbladder Disease			Renal Disease	
	Atrial Fibrillation			GERD			Seizure Disorder	
	Benign Prostatic Hypertrophy			Hepatitis C			Thyroid Disease	
	Blood Clots			Hyperlipidemia			TAH/BSO	
	Cancer type:			Hypertension			Thyroid Disease	
	Cerebrovascular Acciden			Irritable Bowel Syndrome				
	COPD			Liver Disease				

PAST SURGICAL HISTORY: *Please check those applicable and indicate the year.*

✓		*Year*	✓		*Year*	✓	*Gender Specific*	*Year*
	Angioplasty			Gastric Bypass			Augmentation Mammoplasty	
	Anio w/stent			Hernia Repair			Bilat. Tubal Ligation	
	Appendectomy			Hip Replacement L / R			Breast Biopsy	
	Arthroscopy Knee L / R			Knee Replacement L / R			Cesarean Section	
	Back Surgery			LASIK			D&C	
	CABG			Liver Biopsy			Hysterectomy	
	Carpal Tunnel Syndrome			ORIF			Mastectomy	
	Cataract Extraction			Pacemaker			Myomectomy	
	Cholecystecomy			Small Bowel Resection			Reduction Mammoplasty	
	Colectomy			Thryoidectomy			TAH/BSO	
	Colostomy			Tonsillectomy			Vaginal Hysterectomy	

GYNECOLOGICAL/OBSTETRIAL HISTORY: *(Gender Specific)*

Last Menstrual Period: _________ Age at onset of Period: _________

# of Pregnancies: _________ # of Live Births: _________ Stillborn: _________ Miscarriages: _________

Post-Menopausal: _________ Age at Menopause: _________

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

Illness	*Which family member?*	*Age of onset*	*Cause of Death*
Cancer (Describe type)	______________________	__________	☐
Hypertension (High Blood Pressure)	______________________	__________	☐
Heart Disease	______________________	__________	☐
Diabetes	______________________	__________	☐
Stroke	______________________	__________	☐
Mental Disease	______________________	__________	☐
Drug or Alcohol Addiction	______________________	__________	☐
Glaucoma	______________________	__________	☐
Bleeding Diseases	______________________	__________	☐

SOCIAL HISTORY:

Do you smoke? ☐YES ☐NO *If yes, how many packs per day?* ________ # of Years: ________ Year quit: ________

Do you drink alcoholic beverages? ☐YES ☐NO
If yes, what type? ________ Frequency: ________ Amount: ________ Last Drink: ________

Do you drink coffee? ☐YES ☐NO IF yes, how many cups per day? ________

Do you drink tea: ☐YES ☐NO IF yes, how many cups per day? ________

Do you use drugs: ☐YES ☐NO If yes, please explain: ______________________________
(Marijuana, cocaine, crack, etc.)

Do you exercise regularly? ☐YES ☐NO IF yes, type: ___________ Duration: ___________ Frequency: ___________

Advance Directives in place: ☐NONE ☐DNR ☐Living Will

Occupation: ______________________ Employer: ______________________

PATIENT SIGNATURE: ______________________________ DATE: ____________________