INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

ALLERGIES List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you. ALLERGY REACTION				
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Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers. DRUG NAME	List anything that you are allergic t ALLERGY	, , , , , , , , , , , , , , , , , , , ,	•	
### FAYORITE PHARMACY MEDICATIONS				_
Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers. DRUG NAME				-
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Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers. STRENGTH FREQUENCY TAKEN 1 2 3 4 4 5 6 7 7 8 8 9 9 10 IMMUNIZATION HISTORY Immunizations and most recent date: Chickenpox Date: Date: Meningococcus Pneumonia Gardas/IHPV Date: Gardas/IHPV Date: Hepatitis A Date: Tetanus Date: Tetanus Date: Tetanus Date: WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY Last PAP Smear Date: Abnormal Last Mammogram Date: Bieeding between periods Last mammogram Date: Abnormal Last Mammogram Date: Abnormal Last Mammogram Date: Abnormal Last Mammogram Date: Bieeding between periods Last mammogram Date: Bieeding between			<u> </u>	
	-		over-the-counter drugs, such as vitamins and inhalers.	
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Immunizations and most recent date: Chickenpox				
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Chickenpox	10			
☐ Chickenpox Date: Meningococcus Date: MMR (Measles, Mumps, Rubella) Date: Date: Date: MMR (Measles, Mumps, Rubella) Date: Date			IMMUNIZATION HISTORY	
☐ Flu Shot Date:	Immunizations and most recent da	te:		
Gardasil/HPV Date:	Chickenpox	Date:	☐ Meningococcus	Date:
☐ Hepatitis A Date:	☐ Flu Shot		MMR (Measles, Mumps, Rubella)	Date:
Hepatitis B Date:	☐ Gardasil/HPV	Date:	Pneumonia	Date:
Zostavax (Shingles) Date:		Date:	☐ Tdap (Tetanus and pertussis)	Date:
Cesarean sections If yes, then number:	☐ Hepatitis B	Date:	☐ Tetanus	Date:
Last PAP Smear Date Abnormal Bleeding between periods Heavy periods Extreme menstrual period: Extreme menstrual pain Vaginal itching, burning, or discharge Wake in the night to go to the bathroom Hot flashes Breast lump or nipple discharge Painful intercourse Sexually active Current sexual partner is Female Male Do you use condoms Yes No Other Birth control method used:			Zostavax (Shingles)	Date:
Last Mammogram Date Abnormal Heavy periods Extreme menstrual period: Vaginal itching, burning, or discharge Wake in the night to go to the bathroom Hot flashes Breast lump or nipple discharge Painful intercourse Sexually active Current sexual partner is Female Male Do you use condoms Yes No Other Birth control method used:		(WOMEN ONL)	() OBSETRIC AND GYNECOLOGICAL HISTORY	
Last Mammogram Date Abnormal Heavy periods Extreme menstrual period: Vaginal itching, burning, or discharge Wake in the night to go to the bathroom Hot flashes Breast lump or nipple discharge Painful intercourse Sexually active Current sexual partner is Female Male Do you use condoms Yes No Other Birth control method used:	Last PAP Smear Date	☐ Abnormal	☐ Bleeding between periods	
Age of first menstrual period:			_	
Number of pregnancies: births:				
miscarriages: abortions: Hot flashes			☐ Vaginal itching, burning, or discharge	
Cesarean sections If yes, then number: Hot flashes Breast lump or nipple discharge Painful intercourse Sexually active Current sexual partner is Female Male Do you use condoms Yes No Other Birth control method used:			_	
□ Painful intercourse □ Sexually active □ Current sexual partner is □ Female □ Male □ Do you use condoms □ Yes □ No □ Other Birth control method used: □ Do you use contom to the provided in			☐ Hot flashes	
☐ Sexually active Current sexual partner is ☐ Female ☐ Male Do you use condoms ☐ Yes ☐ No Other Birth control method used:	Lesarean sections If yes, the	en number:	☐ Breast lump or nipple discharge	
Current sexual partner is ☐ Female ☐ Male Do you use condoms ☐ Yes ☐ No Other Birth control method used:			Painful intercourse	
Other Birth control method used:				
			Current sexual partner is Female Male Do you use condoms Yes No Other Birth control method used: Interested in being screened for STD's	·