

**Charleston Internal Medicine, Inc.
New Patient Health History**

Name: _____

Date of Birth: ___/___/___

Allergies

Are you allergic to any medication(s)? If yes, list the medication and the allergic reaction.

Do you have any food or environmental allergies? If yes, list the substance and the allergic reaction.

Patient Medical History

Have you been diagnosed with any of the following conditions?

- | | | |
|--|---|--|
| <input type="radio"/> Anxiety | <input type="radio"/> COPD | <input type="radio"/> Heart Disease |
| <input type="radio"/> Arthritis-Type _____ | <input type="radio"/> Coronary Artery Disease | <input type="radio"/> High Blood Pressure |
| <input type="radio"/> Asthma | <input type="radio"/> Depression | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Cancer-Type _____ | <input type="radio"/> Diabetes-Type _____ | <input type="radio"/> Stroke |
| <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Elevated Cholesterol | <input type="radio"/> Thyroid Disease-Type _____ |
| <input type="radio"/> Other _____ | | |
| <input type="radio"/> Other _____ | | |

Surgical History

Have you had any surgeries or procedures?

- | | Date | | Date | | Date |
|------------------------------------|-------|--------------------------------------|-------|-------------------------------------|-------|
| <input type="radio"/> Appendectomy | _____ | <input type="radio"/> Heart Surgery | _____ | <input type="radio"/> Orthopedic | _____ |
| <input type="radio"/> Breast | _____ | <input type="radio"/> Hysterectomy | _____ | <input type="radio"/> Prostate | _____ |
| <input type="radio"/> Cataract | _____ | <input type="radio"/> Laparoscopy | _____ | <input type="radio"/> Thyroid | _____ |
| <input type="radio"/> Gallbladder | _____ | <input type="radio"/> Lesion Removal | _____ | <input type="radio"/> Tonsillectomy | _____ |
| <input type="radio"/> Other _____ | | | | | |
| <input type="radio"/> Other _____ | | | | | |

Family Medical History

Have any of your family members Mother, Father, Brother, Sister, Maternal or Paternal Grandparents, Aunt, Uncle been diagnosed with the following? List age the relative was diagnosed.

- | | Relative | Age | | Relative | Age |
|---|----------|-------|-------------------------------------|----------|-------|
| <input type="radio"/> Cancer-Type _____ | _____ | _____ | <input type="radio"/> Hypertension | _____ | _____ |
| <input type="radio"/> Diabetes-Type _____ | _____ | _____ | <input type="radio"/> Stroke | _____ | _____ |
| <input type="radio"/> Thyroid-Type _____ | _____ | _____ | <input type="radio"/> Heart Disease | _____ | _____ |
| <input type="radio"/> Other _____ | | | | | |
| <input type="radio"/> Other _____ | | | | | |

Screening History

Have you had a Colonoscopy? **Yes/No** If yes, what was the date of your last Colonoscopy? ___/___/___

Social History

Have you ever used tobacco products?

	Daily Amount Used	Age Started	Age Stopped
<input type="radio"/> Cigarette	_____	_____	_____
<input type="radio"/> Smokeless tobacco	_____	_____	_____

Vaccine History

Have you had the following vaccines? If yes, list date the vaccine was received.

	Date Received
<input type="radio"/> Tdap or Adacel (Tetanus, diphtheria, pertussis)	_____
<input type="radio"/> Prevnar 13 (Pneumonia 13)	_____
<input type="radio"/> Pneumococcal 23	_____
<input type="radio"/> Influenza	_____

Have you seen any specialist within the last 12 months? If yes, list the provider's name and specialty.

Medication History

Please bring all prescription, over the counter, vitamins/supplement bottles to your visit that you are currently taking. If you do not bring the medication bottles you may be asked to reschedule your office visit.

I attest the above information was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature of patient or legal guardian

___/___/___
Date