HENDERSON
INTERNAL MEDICINE

Patient History Form	
Name:	Birth date:
Marital Status:	Occupation:

Allergies to Medications, Latex or Dyes	☐None ☐ Yes (please list)

Medications (Prescriptions, non-prescriptions, vitamins and supplements) ☐None ☐ Yes (please list)	

Surgeries/Hospitalizations/Serious Injuries	Year

Immunizations	N	Y		Immunizations	N	Y
Hepatitis B Series				Recent Pneumonia Vaccine		
Gardasil Series				Recent Flu Vaccine		
Chicken Pox immunization or disease				Positive TB Screening		

Health Maintenance	No	Yes	(Year)		Health Maintenance	No	Yes	(Year)
Colonoscopy					Bone Density			
Mammogram					Eye Exam			
Pap Smear					Physical Exam			

Social History	No	Yes	
Smoking			Pack(s)/day /years ☐ Quit
Alcohol			Drinks/day drinks/week
Caffeine			Drinks/day
Recreational Drugs			
Special Diet			If yes describe:
Regular Exercise			If yes describe:
Sexually Active			☐ Men ☐ Women ☐ Both

GYN History	OB History
Age of first mensus: ( ) Menopause ☐ N ☐ Y (if yes Age:)	Total Number of Pregnancies: ( )
Regular Periods ☐ N ☐ Y Painful Periods ☐ N ☐ Y	Full Term ( ) Pre Term ( )
PMS ☐ N ☐ Y – if yes describe	Miscarriages ( ) Abortions ( )
Abnormal Pap: – if Yes approximate date ( )	Tubal ( )
Pain with intercourse: ☐ N ☐ Y	Content with sex life: ☐N ☐ Y

Medical History (please check if positive)

ENT		GENITOURINARY		SKIN	
	Eye Problems		Urinary Infections		Psoriasis
	Sinus Problems		Kidney Disease/Stones		Skin Disorders
	Hearing Loss		Erectile Dysfunction		Melanoma
			STD		
CARDIOVASCULAR			Urinary Incontinence		
	Abnormal EKG	MUSCULOSKELETAL		PSYCH	
	Chest Pain		Arthritis/Osteo		ADD/ADHD
	Heart Attack		Arthritis/Rheumatoid		Anxiety
	Heart Disease		Gout		Depression
	High Blood Pressure		Neck/Spinal Problems		Memory Loss
	High Cholesterol	NEUROLOGICAL			OCD
	Stroke		Concussion		Suicidal Thoughts/attempt
	Peripheral Vascular Disease		Headaches		
PULMONARY			Migraines		
	Asthma		Epilepsy/Seizures		
	Emphysema/COPD	HEMATOLOGICAL			
	Shortness of Breath		Anemia		
	Sleep Apnea		Bleeding Disorders		
GASTROINTESTINAL			Blood Clots		
	Acid Reflux		Cancer		
	Constipation		Sickle Cell Disease		
	Diarrhea	ENDOCRINE			
	Irritable Bowel		Diabetes		
	Gall Bladder Disease		Thyroid Disease		
	Hernia		Pancreatitis		
	Liver Disease				

Family History (please check all applicable boxes)

Illness	Father	Mother	Sibling	Child	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Other
Asthma									
Bleeding Disorders									
Breast Cancer									
Colon Cancer									
Depression/Anxiety									
Diabetes									
Drug/Alcohol Addiction									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Leukemia									
Liver Disease									
Lung Cancer									
Osteoporosis									
Ovarian Cancer									
Pancreatic Cancer									
Rheumatoid Arthritis									
Stroke									
Thyroid Disease									
Other:									