

Winder Internal Medicine and Geriatrics Center P.C.

20 Satellite Dr. Ste 100, Winder, GA 30680

Name _____ Date of Birth _____ / _____ / _____
Last First

Current Medications (Include all Prescriptions, Supplements, Over the Counter and Herbal Medications)

	<u>Name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Diagnosis</u> (asthma, depression...etc)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Allergies / Intolerances

Do You Have Allergies / Intolerances to Medication or Other Substance <input type="checkbox"/> No <input type="checkbox"/> Yes, Please List:	1		3	
	2		4	

Past Medical Problems (Diabetes, Hypertension, Thyroid...etc)

	<u>Problem</u>	<u>Date / Age Diagnosed</u>		<u>Problem</u>	<u>Date / Age Diagnosed</u>
1			5		
2			6		
3			7		
4			8		

Past Surgeries

	<u>Surgery</u>	<u>Date</u>		<u>Surgery</u>	<u>Date</u>
1			3		
2			4		

Family History

(Please indicate if they have or ever had any of the following medical conditions)

<p><u>Father</u></p> <p><input type="checkbox"/> Alive Age or DOB _____</p> <p><input type="checkbox"/> Deceased Cause and age of death. _____</p>	<p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Elevated Cholesterol Levels</p> <p><input type="checkbox"/> Diabetes, Type 2 Type 1</p> <p><input type="checkbox"/> Coronary Heart Disease, Age Diagnosed _____</p> <p><input type="checkbox"/> Stroke, Age Diagnosed _____</p> <p><input type="checkbox"/> Prostate Cancer, Age Diagnosed _____</p> <p><input type="checkbox"/> Colon Cancer, Age Diagnosed _____</p> <p><input type="checkbox"/> Other, _____</p>
<p><u>Mother</u></p> <p><input type="checkbox"/> Alive Age or DOB _____</p> <p><input type="checkbox"/> Deceased Cause and age of death. _____</p>	<p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Elevated Cholesterol Levels</p> <p><input type="checkbox"/> Diabetes, Type 2 Type 1</p> <p><input type="checkbox"/> Coronary Heart Disease, Age Diagnosed _____</p> <p><input type="checkbox"/> Stroke, Age Diagnosed _____</p> <p><input type="checkbox"/> Colon Cancer, Age Diagnosed _____</p> <p><input type="checkbox"/> Breast Cancer, Age Diagnosed _____</p> <p><input type="checkbox"/> Ovarian Cancer, Age Diagnosed _____</p> <p><input type="checkbox"/> Other, _____</p>
<p><u>Siblings</u></p> <p>Number of Brothers _____</p> <p>Sisters _____</p>	<p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Elevated Cholesterol Levels</p> <p><input type="checkbox"/> Diabetes, Type 2 Type 1</p> <p><input type="checkbox"/> Coronary Heart Disease, Age Diagnosed _____</p> <p><input type="checkbox"/> Stroke, Age Diagnosed _____</p> <p><input type="checkbox"/> Colon Cancer, Age Diagnosed _____</p> <p><input type="checkbox"/> Breast Cancer, Age Diagnosed _____</p> <p><input type="checkbox"/> Ovarian Cancer, Age Diagnosed _____</p> <p><input type="checkbox"/> Prostate Cancer, Age Diagnosed _____</p> <p><input type="checkbox"/> Other, _____</p>
<p><u>Children</u></p> <p>Number of Sons _____</p> <p>Daughters _____</p>	<p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p>

Social History

Smoking:

Current Smoker No Yes Packs per Day _____ For How Many Years _____

Previous smoker No Yes Packs per Day _____ For How Many Years _____ Quite Date _____

Alcohol: No Social Yes How much and how often, Type _____

Marital Status: Single Married Divorced Widowed Engaged

Occupation:

Review of Systems

Are you currently or regularly experience any of the following signs and symptoms (please check all that apply)

Constitutional	Endocrine	Genitourinary
<input type="checkbox"/> Weight loss or gain <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Unrefreshed feeling after sleep <input type="checkbox"/> Chronic fatigue	<input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive urination <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Diminished sexual drive	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Urinary incontinence (leakage) <i>Men only</i> <input type="checkbox"/> Difficulty with erection <input type="checkbox"/> Pain or mass in testicles <input type="checkbox"/> Weak urine stream <i>Female only</i> <input type="checkbox"/> Heavy / irregular menstrual bleeding <input type="checkbox"/> Pain during or following intercourse <input type="checkbox"/> Lumps in breast or nipple discharge <input type="checkbox"/> Hot flashes <input type="checkbox"/> Menopause, Age _____ <input type="checkbox"/> Post menopausal vaginal bleeding
Skin	Cardiovascular	
<input type="checkbox"/> New skin rashes or moles <input type="checkbox"/> Changes to existing skin lesions	<input type="checkbox"/> Chest pain or tightness (angina) <input type="checkbox"/> Skipping heart beat (palpitation) <input type="checkbox"/> Trouble breathing when lying flat <input type="checkbox"/> Leg pain / cramps with walking <input type="checkbox"/> Swelling in legs	
Eyes	Respiratory	
<input type="checkbox"/> Diminished or blurred vision <input type="checkbox"/> Wear glasses or contact lenses <input type="checkbox"/> Last Eye Exam	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Persistent cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing	
Ears, Nose, Mouth and Throat	Gastrointestinal	
<input type="checkbox"/> Difficulty hearing <input type="checkbox"/> Feeling of food stuck in throat or chest <input type="checkbox"/> Last Dental Exam	<input type="checkbox"/> Heartburn or sour taste in mouth <input type="checkbox"/> Constipation <input type="checkbox"/> Chronic diarrhea <input type="checkbox"/> Changes in bowel habits <input type="checkbox"/> Blood in stool	
Allergic / Immunologic		
<input type="checkbox"/> Frequently suffer from allergic symptoms such as (Itchy eyes, runny nose or sneezing) <input type="checkbox"/> Animal or food allergies		
Hematologic / Lymphatic		
<input type="checkbox"/> Swollen glands or lymph nodes <input type="checkbox"/> Easy bruising		
		Musculoskeletal
		<input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling or redness <input type="checkbox"/> Joint stiffness
		Neurological
		<input type="checkbox"/> Tingling <input type="checkbox"/> Tremors
		Psychiatric
		<input type="checkbox"/> Depression / sadness <input type="checkbox"/> Feel like hurting someone or self <input type="checkbox"/> Anxiety

Preventive Medicine

Colonoscopy: Date _____ Result _____

Women: Last: Pap smear: _____ / _____ Breast Exam: _____ / _____ Mammogram: _____ / _____

Men: Last: Rectal/Prostate exam: _____ / _____ Testicular exam: _____ / _____ PSA: _____ / _____

Immunization History

Flu: No Yes Date _____ / _____

Pneumonia: No Yes Date _____ / _____

Tetanus: No Yes Date _____ / _____

Hepatitis B vaccine: No Yes Date _____ / _____

Gardasil: No Yes Date _____ / _____

Zoster/Shingles: No Yes Date _____ / _____