Grove Internal Medicine — History Form

Name: _____ DOB: _____ Age: _____ Date: _____

Address: _____ Occupation: _____

Phone (home): _____ (cell): _____ (work): _____ SS# _____

Chief Complaint: _____

DRUG ALLERGIES

1)
2)
3)

CURRENT MEDS/DOSAGE

1)
2)
3)
4)
5)

FAMILY HISTORY

Indicate Yes or No	Father	Mother	Siblings	Children
Heart disease				
High Blood Pressure				
Stroke				
Cancer				
Glaucoma				
Diabetes				
Epilepsy/Convulsion				
Bleeding Disorder				
Kidney Disease				
Thyroid Disease				
Mental Illness				
Other (please indicate illness)				

HOSPITALIZATION/SURGERIES

DATE	REASON

MEDICAL HISTORY: Circle all that apply

○Headache	○Allergies/Hay fever	○GI Disorder	○Venereal Disease	○Scarlet Fever	○Tetanus
○Shortness of Breath	○Asthma	○Lactulose intolerance	○Gout	○Frequent Infection	○Diphtheria
○Heart palpitations	○Bronchitis	○Gallbladder Disease	○Hepatitis	○Chronic rashes	○Polio
○Heart Murmurs	○Pneumonia	○Prostate Disease	○Anemia	○Rheumatic fever	○Rubella
○Chest Pain	○Ulcer	○Bowel Irregularity	○Arthritis	○Mumps	
○Dizziness/Fainting	○Osteoporosis	○Incontinence	○Depression	○Measles	
○Nervousness	○Peripheral Vascular Disease		○Sexual/Menstrual Problems		

HABITS

Smoke: Packs daily: How long: Interest in stopping?:

Alcohol: Type(s): Amount:

Diet: Salt intake: Fat intake:

Exercise routinely: **Coffee**: Cups daily: Other Caffeine:

Sleep: Difficulty falling asleep: Continuity disturbances: Snoring:

Early morning awakening: Daytime drowsiness:

WOMEN ONLY Pregnant: Planning pregnancy: