

**Mehta Internal Medicine**

**Patient Medical History Form 2**

Patient Name:

DOB:

Visit Date:

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**General**

Weight Loss:  Yes  No  
Decreased appetite:  Yes  No  
Fatigue:  Yes  No  
Fever:  Yes  No  
Night Sweats:  Yes  No

**Gastrointestinal**

Nausea:  Yes  No  
Vomiting:  Yes  No  
Abdominal pain:  Yes  No  
Vomiting Blood:  Yes  No  
Gas:  Yes  No  
Bloating:  Yes  No  
Heartburn:  Yes  No  
Trouble swallowing:  Yes  No  
Stomach Ulcers:  Yes  No  
Change in bowel habits:  Yes  No  
Constipation:  Yes  No  
Diarrhea:  Yes  No

**Endocrine**

Thyroid Problems:  Yes  No  
Low Blood Sugar:  Yes  No

**Eyes**

Glaucoma:  Yes  No  
Cataracts:  Yes  No

**Ear, Nose and Throat**

Dentures:  Yes  No  
Hoarseness:  Yes  No  
Sinusitis:  Yes  No  
Post Nasal drainage:  Yes  No

**Cardiovascular**

Chest pain:  Yes  No  
Palpitations:  Yes  No  
Murmur:  Yes  No  
Heart Attack:  Yes  No  
Abnormal Heart rhythm:  Yes  No

**Respiratory**

Home oxygen:  Yes  No  
Shortness of Breath:  Yes  No  
Chronic cough:  Yes  No  
TB (tuberculosis):  Yes  No

**Skin**

Yellowing (jaundice):  Yes  No  
Rashes:  Yes  No  
Bruising:  Yes  No

**Musculoskeletal**

Arthritis:  Yes  No  
Ongoing Back pain:  Yes  No  
Leg Cramps:  Yes  No

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**Hematologic**

Plavix usage:  Yes  No

Coumadin usage:  Yes  No

Aspirin usage:  Yes  No

Other blood thinner:  Yes  No

Naproxen, Advil, Motrin:  Yes  No

(Non-steroidal anti-inflammatory usage)

Anemia:  Yes  No

Clotting problems:  Yes  No

Prior transfusions:  Yes  No

**Neurologic**

Alzheimer's:  Yes  No

Neuromuscular Disease:  Yes  No

Seizure:  Yes  No

Sleep disturbances:  Yes  No

**Neurologic Cont'd**

Confusion:  Yes  No

Headache:  Yes  No

**Reproductive/Urinary**

Kidney Stones:  Yes  No

Burning w/ Urination:  Yes  No

Blood in urine:  Yes  No

Are you Pregnant?:  Yes  No

**Psychiatric**

History of Mental illness:  Yes  No

Anxiety:  Yes  No

Depression:  Yes  No

Stress:  Yes  No

Memory loss or confusion:  Yes  No

**Family History** **Mark only those that apply or NONE**

**Mother**

Living  Deceased

NONE  Heart Attack  Heart Disease  Peripheral Vascular Disease

Hypertension  High Cholesterol  Diabetes Mellitus  Stroke  Cancer

**Father**

Living  Deceased

NONE  Heart Attack  Heart Disease  Peripheral Vascular Disease

Hypertension  High Cholesterol  Diabetes Mellitus  Stroke  Cancer

**Grandparents**

NONE  Heart Attack  Heart Disease  Peripheral Vascular Disease

Hypertension  High Cholesterol  Diabetes Mellitus  Stroke  Cancer

**Siblings**

NONE  Heart Attack  Heart Disease  Peripheral Vascular Disease

Hypertension  High Cholesterol  Diabetes Mellitus  Stroke  Cancer

**Children**

NONE  Heart Attack  Heart Disease  Peripheral Vascular Disease

Hypertension  High Cholesterol  Diabetes Mellitus  Stroke  Cancer

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**Past Medical History (Mark only those that apply or NONE)**

**NONE**

- |                           |                       |     |                       |                       |     |
|---------------------------|-----------------------|-----|-----------------------|-----------------------|-----|
| GERD/Heartburn:           | <input type="radio"/> | Yes | Pacemaker:            | <input type="radio"/> | Yes |
| Ulcers:                   | <input type="radio"/> | Yes | AICD(Defibrillator):  | <input type="radio"/> | Yes |
| Colon Polyps:             | <input type="radio"/> | Yes | COPD:                 | <input type="radio"/> | Yes |
| Irritable Bowel Syndrome: | <input type="radio"/> | Yes | Diabetes:             | <input type="radio"/> | Yes |
| Diverticulosis:           | <input type="radio"/> | Yes | Elevated Cholesterol: | <input type="radio"/> | Yes |
| Pancreatitis:             | <input type="radio"/> | Yes | Stroke:               | <input type="radio"/> | Yes |
| Crohn's Disease:          | <input type="radio"/> | Yes | Fibromyalgia:         | <input type="radio"/> | Yes |
| Ulcerative Colitis:       | <input type="radio"/> | Yes | Arthritis:            | <input type="radio"/> | Yes |
| Hypertension:             | <input type="radio"/> | Yes | Chronic Back pain:    | <input type="radio"/> | Yes |
| Coronary Artery Disease:  | <input type="radio"/> | Yes | Cancer:               | <input type="radio"/> | Yes |
| Cardiac Stent:            | <input type="radio"/> | Yes | Renal Failure:        | <input type="radio"/> | Yes |
| Congestive Heart Failure: | <input type="radio"/> | Yes | Dialysis:             | <input type="radio"/> | Yes |
| Atrial Fibrillation:      | <input type="radio"/> | Yes | Sleep Apnea:          | <input type="radio"/> | Yes |
| Valvular Heart Disease:   | <input type="radio"/> | Yes |                       |                       |     |

**Social History**

- Marital status:  Married  Single  Divorced  Widowed  Life Partner
- Occupation:  Full Time  Part Time  Retired  Homemaker  
 Student  Unemployed  Disabled
- Smoke:  Yes  No  Trying to Quit  Previous smoker
- Smokeless Tobacco:  Yes  No  Trying to Quit  Previously
- Alcohol:  Never  Daily  Social Drinker  Trying to Quit  Recovering Alcoholic
- Illegal Drugs:  Yes  No  Recovering Addict
- Tattoos:  Yes  No
- HIV infected:  Yes  No  Unknown (never been tested)
- Who Lives with you:  Spouse  Children  Partner  Mother  Father  No one

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**Surgical History**

**NONE**  (Please mark NONE if nothing below applies)

- |                          |                                       |                        |                                       |
|--------------------------|---------------------------------------|------------------------|---------------------------------------|
| Colonoscopy:             | <input type="radio"/> Yes Year: _____ | Breast Cancer Surgery: | <input type="radio"/> Yes Year: _____ |
| EGD(Upper endoscopy):    | <input type="radio"/> Yes Year: _____ | Prostate Surgery:      | <input type="radio"/> Yes Year: _____ |
| Ulcer Surgery:           | <input type="radio"/> Yes Year: _____ | Back Surgery:          | <input type="radio"/> Yes Year: _____ |
| Colon Surgery:           | <input type="radio"/> Yes Year: _____ | Hip Surgery:           | <input type="radio"/> Yes Year: _____ |
| Cholecystectomy:         | <input type="radio"/> Yes Year: _____ | Knee Surgery:          | <input type="radio"/> Yes Year: _____ |
| Appendectomy:            | <input type="radio"/> Yes Year: _____ | Other Knee Surgery:    | <input type="radio"/> Yes Year: _____ |
| Hemorrhoidectomy:        | <input type="radio"/> Yes Year: _____ | Weight Loss Surgery:   | <input type="radio"/> Yes Year: _____ |
| Bypass Surgery:          | <input type="radio"/> Yes Year: _____ | _____:                 | <input type="radio"/> Yes Year: _____ |
| Heart Valve Replacement: | <input type="radio"/> Yes Year: _____ | _____:                 | <input type="radio"/> Yes Year: _____ |
| Hysterectomy:            | <input type="radio"/> Yes Year: _____ | _____:                 | <input type="radio"/> Yes Year: _____ |
| Ovaries Removed:         | <input type="radio"/> Yes Year: _____ |                        |                                       |

Prescription Medications: \_\_\_\_\_

Over the Counter Medications: \_\_\_\_\_

Diet Pills & Herbal Medications: \_\_\_\_\_ Yes \_\_\_\_\_ NO Examples include, but not limited to, diet pills,

St. John's Wort, Epedra, Garlic, Ginko : \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_ Yes \_\_\_\_\_ NO Please list: \_\_\_\_\_

Latex Allergies: \_\_\_\_\_ Yes \_\_\_\_\_ NO

List all current Doctors: \_\_\_\_\_