Welcome to the offices of Internal Medicine Associates, Drs. Richard Cassoff, Hans Fuchs, Stephanie Perry, Richard Schollaert and Physicians Assistants Sarah Miller and Anastasia Barthelemy. Please complete this questionnaire to help us gather important information about your health.

Name: _____ Date of Birth:_____ Date:_____

1. Please circle if you have had any of the following diagnosis:

1. High blood pressure
2. Diabetes
3. Cancer :

Type_____

4. Heart Disease:

Type_____

5. Palpitations
6. Stroke
7. Glaucoma
8. Thyroid Disease:

Type_____

9. Lung Disease:

Type_____

10. Liver Disease:

Type_____

11. Kidney Disease:

Type_____

12. Tuberculosis
13. Arthritis
14. Migraines
15. Seizures
16. High Cholesterol
17. Autoimmune Disease
18. Dementia
19. Gout
20. Anxiety and/or depression
21. Falls
22. Environmental allergies
23. Osteoporosis
24. Enlarged Prostate
25. Abnormal Paps
26. Hysterectomy
27. Incontinence
28. Other:

_____
_____
_____
_____
_____

2. Please list surgeries you have had:

_____
_____
_____

3. Please list any specialist you see on a regular basis:

_____
_____
_____

4. Please list medications you are taking currently along with dose and how often (including over the counter):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

5. Do you have any allergies to any medicines? Yes No 6a. Are you allergic to **LATEX**? Yes No

Please list with type of reaction_____

_____

Name: _____ Date of Birth:_____

6. **Family History** – Please indicate if any of these problems run in your family **and** indicate family member:

	Mother	Father	Sister(s)	Brother(s)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Son(s)	Daughter(s)
1. Diabetes										
2. Kidney Disease										
3. High Blood Pressure										
4. Stroke										
5. Thyroid Disease										
6. Heart Disease										
7. Obesity										
8. Colon Cancer										
9. Breast Cancer										
10. Other Cancer: Please indicate type under appropriate family member										
11. Liver Disease										
12. Depression										
13. Alcoholism										
14. Addiction										
15. Other Please indicate problem under appropriate family member										
16. Deceased: Please indicate cause under appropriate family member										

7. **Social History / Health Habits**

A. Please Circle: Do you smoke? Yes No <u>Cigarettes, Cigar, Pipe</u> How often_____

Ai. Are you a former smoker? Yes No When did you quit?_____

Aii. How many years have/did you smoke?_____

B. Do you drink caffeine? Yes No How much per day?_____

C. Do you drink alcohol? Yes No How often?_____

Name: _____ Date of Birth:_____

D. Do you use any recreational drugs? Yes No Former user If yes, what type_____

E. Do you wear a seat belt? Yes No

Ei. Do you wear a bike/motorcycle helmet? Yes No Not Applicable

F. What is your occupation?_____

Have you been exposed to asbestos, or other known occupational hazards? Yes No

G. Marital status? Married, Separated, Domestic Partner, Divorced, Single, Widowed

Who lives in your household?_____

H. (Females only) If you have children: How many pregnancies_____ How many deliveries_____?

I. Are you sexually active? Yes No Do you use any form of birth control Yes: Type_____ No

J. Do you exercise? Yes No How often?_____

K. Do you get an annual flu shot? Yes No

L. Have you ever had a pneumonia shot? Yes No When?_____

M. When was your last tetanus shot?_____

N. Do you have a living will? Yes No

Females Only

A. Are you still menstruating? Yes No Last menstrual period?_____

B. Have you ever had a mammogram? Yes No Last exam?_____

C. When was your last pelvic exam?_____ Have you ever had an abnormal Pap? Yes No

Please check the following conditions that pertain to you.

General

- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

Skin

- ☐ Rash
- ☐ Itching
- ☐ Color changes
- ☐ Hair / Nail changes

Head

- ☐ Headache
- ☐ Head injury

Ears

- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Drainage
- ☐ Wear hearing aid(s)

Eyes

- ☐ Vision loss/changes
- ☐ Blurred or double vision
- ☐ Pain
- ☐ Redness
- ☐ Cataracts
- ☐ Glasses or contacts

Nose

- ☐ Stuffiness
- ☐ Drainage
- ☐ Nosebleeds

Mouth/Throat

- ☐ Dentures
- ☐ Bleeding gums
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Non-healing sores

Neck

- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

Breasts

- ☐ Lumps
- ☐ Pain
- ☐ Discharge

Respiratory

- ☐ Cough
- ☐ Coughing up mucus
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Painful breathing

Cardiovascular

- ☐ Chest pain
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of breath w/ activity
- ☐ Difficulty breathing lying down
- ☐ Swelling
- ☐ Awaken short of breath
- ☐ Fainting spells
- ☐ Pacemaker

Gastrointestinal

- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea / Vomiting
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Liver Disease
- ☐ Yellow eyes or skin

Urinary

- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Waking up a night to urinate
- ☐ Urine leakage
- ☐ Kidney disease
- ☐ Kidney stones

Vascular

- ☐ Calf Pain and walking
- ☐ Leg cramping

Musculoskeletal

- ☐ Muscle or joint pain
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Back pain
- ☐ Stiffness
- ☐ Redness of joints
- ☐ Swelling of joints

Neurologic

- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

Hematologic

- ☐ Ease of bruising
- ☐ Ease of bleeding

Endocrine

- ☐ Heat or cold intolerance
- ☐ Sweating
- ☐ Thirst

Psychiatric

- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory loss