

Welcome to the offices of Edgeworth Internal Medicine, Drs. Hans Fuchs, Stephanie Perry, and Physicians Assistant 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 | 10. Liver Disease:
Type _____ | 21. Falls |
| 2. Diabetes | 11. Kidney Disease:
Type _____ | 22. Environmental allergies |
| 3. Cancer :
Type _____ | 12. Tuberculosis | 23. Osteoporosis |
| 4. Heart Disease:
Type _____ | 13. Arthritis | 24. Enlarged Prostate |
| 5. Palpitations | 14. Migraines | 25. Abnormal Paps |
| 6. Stroke | 15. Seizures | 26. Hysterectomy |
| 7. Glaucoma | 16. High Cholesterol | 27. Incontinence |
| 8. Thyroid Disease:
Type _____ | 17. Autoimmune Disease | 28. Other:

_____ |
| 9. Lung Disease:
Type _____ | 18. Dementia | |
| | 19. Gout | |
| | 20. Anxiety and/or depression | |

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. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 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 Cigarettes, Cigar, Pipe 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