Tennessee Valley Internal Medicine, P.C.

Name: ______________________________ **DOB**: __________ **Today's Date**: ___________

Previous Medical Providers name and address: ____

____

____

Emergency contact name (and relation to patient) and phone #: _________________________________

MEDICATIONS (PRESCRIPTION & OVER THE COUNTER MEDICINE) INCLUDE NAME, DOSAGE & FREQUENCY**:**

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

DRUG ALLERGIES?____

MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS OR OPERATIONS:

PROBLEM/DATE	PROBLEM/DATE	PROBLEM/DATE

Have you had a transfusion of blood or blood products? ☐ Yes ☐ No If yes did you have any reaction? ☐ Yes ☐ No

PERSONAL & SOCIAL HISTORY

ALCOHOL/TOBACCO/DRUGS RISK SCREEN:

Do you use cigarettes, pipes, cigars or chew tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Has your drinking affected your employment or relationship with your family & friends? ☐ Yes ☐ No ☐ NA

Do you drink coffee, sodas or other caffeinated beverages? ☐ Yes ☐ No

Do you use any street drugs or abuse prescription pain medication? ☐ Yes ☐ No

SOCIAL HISTORY

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Separated

Education: ☐ Jr. High School ☐ High School/GED ☐ Vocational School ☐ College ☐ Other: __________

Occupation: ______________________ Do you have an Advance Directive? ☐ Yes ☐ No

Do you routinely exercise? ☐ Yes ☐ No If yes, how often do you exercise? ________________

FAMILY HISTORY

FAMILY MEMBER	AGE	ALIVE / DECEASED	HEALTH	CAUSE OF DEATH
Mother		☐ Alive ☐ Deceased		
Father		☐ Alive ☐ Deceased		
1. ☐ Brother ☐ Sister		☐ Alive ☐ Deceased		
2. ☐ Brother ☐ Sister		☐ Alive ☐ Deceased		
3. ☐ Brother ☐ Sister		☐ Alive ☐ Deceased		
4. ☐ Brother ☐ Sister		☐ Alive ☐ Deceased		

FAMILY HISTORY			RELATIVE				RELATIVE
1. Alzheimer's Disease	☐ Yes	☐ No	___________	11. Iron Storage Disease	☐ Yes	☐ No	___________
2. Breast Cancer	☐ Yes	☐ No	___________	12. High Blood Pressure	☐ Yes	☐ No	___________
3. Heart Disease	☐ Yes	☐ No	___________	13. Ovarian Cancer	☐ Yes	☐ No	___________
4. Stroke	☐ Yes	☐ No	___________	14. Prostate Cancer	☐ Yes	☐ No	___________
5. Depression, Suicide	☐ Yes	☐ No	___________	15. Skin Cancer	☐ Yes	☐ No	___________
6. Diabetes	☐ Yes	☐ No	___________	16. Thyroid Disease	☐ Yes	☐ No	___________
7. High Cholesterol	☐ Yes	☐ No	___________	17. Sickle Cell Disease	☐ Yes	☐ No	___________
8. Obesity	☐ Yes	☐ No	___________	18. Anemia	☐ Yes	☐ No	___________
9. Glaucoma	☐ Yes	☐ No	___________	19. Macular degeneration	☐ Yes	☐ No	___________
10. Substance Abuse	☐ Yes	☐ No	___________	20. Other: ___________			

HEALTH MAINTENANCE

Last Colonoscopy: _________ Cardiac stress test: __________ Bone Density Exam: ___________
Dental Exam: __________ Eye Exam: __________ Routine Fasting Labs: __________

WOMEN: Last: PAP smear: _________ Mammogram: _______ Breast Exam: ________ Menstrual Period: ____________

MEN: Last: Rectal/Prostate exam: _________ Testicular Exam: __________ PSA: __________

IMMUNIZATIONS: (last date/year received) Tetanus: __________ Hepatitis B vaccine: ___________ MMR: ____________
Pneumonia: ________ Flu: _________ Zoster Vaccine: ________ HPV Vaccine: ________ TB Test (date & results): ________________

Please review the list of symptoms below.

Check "Yes" box if you suffer from the symptoms or have any of the health issues listed in the past 6 months Check "No" box if you do not.

CONSTITUTIONAL

Symptom	Yes	No
Unexplained weight loss	☐ Yes	☐ No
Unexplained weight gain	☐ Yes	☐ No
Fevers	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Nausea or Vomiting	☐ Yes	☐ No

EYES

Symptom	Yes	No
Cataract	☐ Yes	☐ No
Change in vision	☐ Yes	☐ No
Glasses	☐ Yes	☐ No
Red eyes	☐ Yes	☐ No

ENT

Symptom	Yes	No
Bleeding from gums	☐ Yes	☐ No
Problems hearing	☐ Yes	☐ No
Change in your voice	☐ Yes	☐ No
Denture	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
Hoarse voice	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No
Ringing in ears	☐ Yes	☐ No
Mouth ulcers	☐ Yes	☐ No

CARDIOVASCULAR

Symptom	Yes	No
Angina	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Leg pain with walking	☐ Yes	☐ No
Problems with exercise	☐ Yes	☐ No
Swelling in legs	☐ Yes	☐ No
Problems lying flat	☐ Yes	☐ No
Skipping heart beats	☐ Yes	☐ No
Short of breath at night	☐ Yes	☐ No

RESPIRATORY

Symptom	Yes	No
Bronchitis	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

SKIN

Symptom	Yes	No
Skin changes	☐ Yes	☐ No
Skin lesions	☐ Yes	☐ No
Skin itching	☐ Yes	☐ No
Rashes	☐ Yes	☐ No
Dry skin	☐ Yes	☐ No

GASTROINTESTINAL

Symptom	Yes	No
Blood in stool	☐ Yes	☐ No
Change in movements	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Heart burn	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
Black tarry stool	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No

GENITOURINARY

Symptom	Yes	No
Problems urinating	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Hernias	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Urination at night	☐ Yes	☐ No
Sexual transmitted Dz.	☐ Yes	☐ No
Urinary urgency	☐ Yes	☐ No

WOMEN ONLY

Symptom	Yes	No
Problems with your period	☐ Yes	☐ No
Vaginal dryness	☐ Yes	☐ No
Problems with sex	☐ Yes	☐ No
Vaginal discharge	☐ Yes	☐ No
Pain in breast	☐ Yes	☐ No
Lumps in breast	☐ Yes	☐ No
Breast discharge	☐ Yes	☐ No

MEN ONLY

Symptom	Yes	No
Problems with erections	☐ Yes	☐ No
Dribbling of urine	☐ Yes	☐ No
Weak urine stream	☐ Yes	☐ No
Pain in testicles	☐ Yes	☐ No

MUSCULAR SKELETAL

Symptom	Yes	No
Neck pain	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Injury to limbs	☐ Yes	☐ No
Joint Pain	☐ Yes	☐ No
Joint stiffness	☐ Yes	☐ No
Locking joints	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Red or Swollen in joints	☐ Yes	☐ No

HEMATOLOGY/ONCOLOGY

Symptom	Yes	No
Anemia or low blood	☐ Yes	☐ No
Easily bruise	☐ Yes	☐ No
Swollen lymph nodes	☐ Yes	☐ No
Cancers	☐ Yes	☐ No

PSYCHIATRIC

Symptom	Yes	No
Depression or Sadness	☐ Yes	☐ No
Feel like hurting someone	☐ Yes	☐ No
Feel like hurting yourself	☐ Yes	☐ No
Problems with memory	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Problems concentrating	☐ Yes	☐ No
Problems sleeping	☐ Yes	☐ No

NEUROLOGY

Symptom	Yes	No
Change in memory	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Imbalance	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

ENDOCRINE

Symptom	Yes	No
Problems with heat	☐ Yes	☐ No
Problems with cold	☐ Yes	☐ No
Swelling in neck	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No
Excessive thirst	☐ Yes	☐ No
Changes in hair	☐ Yes	☐ No

_____________________________ _____________________________ __________
Print Name Signature Date