Bowie Internal Medicine Associates
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Medical & Health History Form

Personal Information

Name_____ Date_____

Occupation: (Present)_____ Number of years_____

(Past)_____ Dates:_____ to _____

(Past)_____ Dates:_____ to _____

Health Information

Medications: Please list all medications, vitamins & herbal supplements you are taking including dosage & frequency information.

Medical problems: Please list any current or past medical problems for which you have undergone treatment.

Surgical procedures/hospitalizations: Please list any surgical procedures or hospitalizations you have undergone along with the dates.

Dates:

Allergies: _____ _____ _____

Last menstrual period:_____

History of blood transfusion: Yes No When?_____

History of emotional_____or physical_____ abuse? When?_____

Past Medical Examinations and Tests:

Last complete physical examination: Date_____ Physician_____

Last PAP smear: Date_____ Result_____

Last mammogram: Date_____ Result_____

Last DEXA (bone density test): Date_____ Result_____

Colon cancer screening: What type?_____ Date_____ Result_____

Last PSA: Date_____ Result_____ Last glucose (blood sugar): Date_____ Result_____

Last cholesterol test: Date_____Result_____ Tuberculosis (PPD): Date_____ Result_____

Habits:

Tobacco: Do you currently smoke? Yes_ No_ If yes, number of cigarettes/cigars/pipes per day ____ for____ years.

Quit in _____.

Alcohol: Do you currently drink? Yes____ No____ If yes, number of drinks per day/week/month_____ for_____ years.

Other drugs:_____ Number of times per day/week/month_____ for_____ years.

Sleep: _____ hours per night (average) Do you nap regularly? Yes_____No_____

Do you wear seat belts? Yes_____ No_____ Do you own guns? Yes_____ No_____

Do you wear bike helmets? Yes_____No_____ Not applicable_____ Do you practice safe sex? Yes____ No_____

Do you perform breast/testicular self-exam? Yes____ No_____ Do you have tattoos? Yes No When?_____

Do you exercise? Yes_____No_____ Type:_____ Frequency: _____

Family History

Name	Age	State of Health	If deceased, cause of death
(Father)			
(Mother)			
(Sibling)			
(Sibling)			
(Child)			
(Child)			
(Paternal grandparents)			
(Maternal grandparents)			

Hereditary conditions: Check if any of the following are present in blood relatives and give the relationship.

( ) High blood pressure_____
( ) Diabetes _____
( ) Kidney disease_____
( ) Epilepsy_____
( ) Mental Illness Type:_____
( ) Cancer Type:_____
( ) Heart disease Age of onset:_____

( ) Bleeding disorders/sickle cell_____
( ) Asthma_____
( ) Arthritis or gout_____
( ) Stroke/CVA_____

Names of other healthcare providers:

_____
_____
_____

Problem(s) for which you are seeing them

_____
_____
_____

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_____ _____

Patient's signature Date

Reviewed by:_____ ___/___/___ _____ ___/___/___ _____ ___/___/___

_____ ___/___/___ _____ ___/___/___ _____ ___/___/___