NorthEast Internal & Integrative Medicine

Adult Patient History

Date:____________________ Chart # ____________________

MRN # ____________________

Name: ____________________ Age:________ Date of Birth:____________ Sex: M F

Marital Status: Single Married Widowed Divorced Occupation: ____________________

Spouse / Significant Other Name: ____________________ Education: Highest Level Completed ________

What is the reason for your visit today? ____________________ Who referred you? ____________________

Vaccines	Approximate Date
Tetanus	
Flu	
Hep B	
Pneumovax	
MMR	
Chicken pox	
TB skin Test Positive Negative	

Exams	Approximate Date
Last Dental Exam	
Last Eye Exam	
Last Chest X-ray	
Last Colonoscopy / Sigmoidoscopy	
Last Mammogram	
Last Pap Smear	
Last Physical Exam	
Last Prostate Exam / PSA	
Other ____________	

PAST MEDICAL & FAMILY HISTORY

Check (✔) if you or any blood relative has or has had any of the following and enter their relationship to you: *(Use the following abbreviations)* ***Y - yourself M - mother F - father B - brother S - Sister GF - grandfather GM - Grandmother C - Child N - None***

Condition	Relationship
Heart disease	
Lung disease *(asthma, bronchitis, emphysema, TB, etc.)*	
Cancer *(breast, prostate, melanoma, leukemia, etc.)*	
Stroke	
High Blood Pressure	
Diabetes	
Liver disease *(hepatitis, cirrhosis, jaundice, etc.)*	
Kidney disorders *(including kidney stones)*	
Arthritis	
Blood disorders *(anemia, bleeding disorders, etc.)*	
High Cholesterol	
Allergies *(food, seasonal)*	

Condition	Relationship
Rheumatic fever	
Stomach / Intestinal disorders	
Gallbladder disorders	
Thyroid disorders *(goiter)*	
Gout	
Skin disorders	
Depression or other Mental Illness	
Sexually transmitted disease *(HIV, Herp., PID, etc.)*	
Alcohol / Drug Abuse	
Risk factors for HIV	
Migraines / Headaches	
Other ____________	

Current Medications - Prescription and Over-The-Counter Meds.
(including vitamins, herbs, aspirin, antacids, injectables, hormones)

Birth Control ***(Oral, Injectable)***

Are you allergic to any medicine? ☐ **Yes** ☐ **No**
Please list all medications and reactions

Past Hospitalizations / surgeries / serious injuries
(including blood transfusions)

Do You	Yes	No	Type	Amt. / Day	Date Quit
Use tobacco products	☐	☐			
Consume alcohol	☐	☐			
Drink caffeine	☐	☐			
Use or used illegal drugs	☐	☐			
Exercise regularly	☐	☐			
Have diet restrictions	☐	☐			
Travel outside US	☐	☐			

Today's Date ______________________ Chart# ______________________

Name ____ MRN# ______________________

INDICATE WHICH APPLY TO YOU

GENERAL	Yes	No
1. Frequent infections	☐	☐
2. Weight change	☐	☐
3. Appetite / thirst change	☐	☐
4. Excessive fatigue / nervousness	☐	☐
5. Difficulty sleeping	☐	☐
6. Enlarged / tender lymph nodes or glands	☐	☐
7. Other ______________		

EYES	Yes	No
1. Do you wear glasses / contacts	☐	☐
2. Vision changes	☐	☐
3. Red / itchy, watery eyes	☐	☐
4. Eye pain	☐	☐
5. Glaucoma	☐	☐
6. Dry eyes	☐	☐
7. Other ______________		

EARS	Yes	No
1. Infections	☐	☐
2. Hearing loss	☐	☐
3. Earaches	☐	☐
4. Ear drainage	☐	☐
5. Buzzing / ringing	☐	☐
6. Feel "stopped up"	☐	☐
7. Other ______________		

NOSE AND THROAT	Yes	No
1. Nasal stuffiness / drainage	☐	☐
2. Frequent nosebleeds	☐	☐
3. Sore throat	☐	☐
4. Mouth sores / ulcers	☐	☐
5. Hoarseness	☐	☐
6. Changes in taste	☐	☐
7. Teeth / gum problems	☐	☐
8. Snoring	☐	☐
9. Sleep apnea (*stop breathing while sleeping*)	☐	☐
10. Other ______________		

PULMONARY	Yes	No
1. Shortness of breath / difficulty breathing	☐	☐
2. Cough - dry / productive	☐	☐
3. Asthma / wheezing	☐	☐
4. Night sweats	☐	☐
5. Fever / chills	☐	☐
6. Other ______________		

CARDIOVASCULAR	Yes	No
1. Heart attack / failure / angina	☐	☐
2. Chest pain / tightness	☐	☐
3. Irregular heartbeat	☐	☐
4. High blood pressure	☐	☐
5. Swelling of feet / ankles	☐	☐
6. Leg cramps with walking	☐	☐
7. Mitral valve / murmur	☐	☐
8. Other ______________		

GASTROINTESTINAL	Yes	No
1. Heartburn / indigestion	☐	☐
2. Difficulty swallowing	☐	☐
3. Stomach pains / ulcers	☐	☐
4. Nausea / vomiting	☐	☐
5. Vomiting blood	☐	☐
6. Loose stools / diarrhea	☐	☐
7. Constipation	☐	☐
8. Hemorrhoids	☐	☐
9. Rectal bleeding	☐	☐
10. Black / bloody stools	☐	☐
11. Changes in bowel habits	☐	☐
12. Frequent laxatives	☐	☐
13. Liver problems / jaundice / hepatitis	☐	☐
14. Gallstones	☐	☐
15. Other ______________		

BREAST	Yes	No
1. Lumps	☐	☐
2. Pain	☐	☐
3. Discharge	☐	☐
4. Other ______________		

MALES ONLY	Yes	No
1. Prostate problems	☐	☐
2. Sexual difficulties	☐	☐
3. Testicle pain / lumps / swelling	☐	☐
4. Impotent	☐	☐
5. Discharge	☐	☐
6. Do you do regular testicle exams	☐	☐
7. Date of last prostate exam / PSA______________		
8. Venereal disease	☐	☐
9. Genital concerns	☐	☐
10. Other		

FEMALES ONLY	Yes	No
1. Excessive menstrual flow	☐	☐
2. Excessive menstrual pain	☐	☐
3. Vaginal discharge / odor	☐	☐
4. Vaginal dryness	☐	☐
5. PMS symptoms	☐	☐
6. Menopause / symptoms	☐	☐
7. Trouble conceiving	☐	☐
8. Problems with pregnancies	☐	☐
9. Sexual difficulties	☐	☐
10. Venereal disease	☐	☐
11. Genital concerns	☐	☐
12. Self breast exams per year______.		
13. You you use birth control Type______________	☐	☐
14. Date of last pap ______________		
15. History of abnormal pap Treatment______________	☐	☐
16. Date of last mammogram______________		
17. Age of onset of periods______________		
18. Frequency of periods______________		

FEMALES ONLY *(continued)*

19. Last Menstrual period ______________
20. Pregnancies ______________
21. Live births ______________
22. Miscarriages / abortions ______________
23. Other______________

MUSCULOSKELETAL	Yes	No
1. Joint pain / tenderness	☐	☐
2. Joint swelling / warmth	☐	☐
3. Joint stiffness	☐	☐
4. Joint deformity	☐	☐
5. Muscle pain	☐	☐
6. Back / neck pain	☐	☐
7. Weakness	☐	☐
8. Prone to falls	☐	☐
9. Other ______________		

SKIN	Yes	No
1. Rashes	☐	☐
2. Dry / itchy skin	☐	☐
3. Bruising	☐	☐
4. Sweats	☐	☐
5. Mole / lesion changes	☐	☐
6. Skin color changes	☐	☐
7. Skin growths	☐	☐
8. Hair / nail problems	☐	☐
9. Other ______________		

NEUROLOGIC	Yes	No
1. Headaches / migraines	☐	☐
2. Dizziness / nausea	☐	☐
3. Fainting / blackouts	☐	☐
4. Numbness / tingling	☐	☐
5. Paralysis	☐	☐
6. Seizures / convulsions	☐	☐
7. Coordination problems	☐	☐
8. Memory loss	☐	☐
9. Other ______________		

PSYCHIATRIC	Yes	No
1. Mental illness	☐	☐
2. Anxiety	☐	☐
3. Depression	☐	☐
4. Suicidal thoughts	☐	☐
5. Overly emotional / mood swings	☐	☐
6. Hallucinations	☐	☐
7. Phobias	☐	☐
8. Other ______________		

URINARY	Yes	No
1. Pain / burning on urination	☐	☐
2. Urinary frequency	☐	☐
3. Difficulty starting urine	☐	☐
4. Incontinence *(wetting)*	☐	☐
5. Bloody Urine	☐	☐
6. Other ______________		

Provider Review:______________________________ Date: ____________

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