KIAS | JARRARD | JOHNSON
INTERNAL MEDICINE
706-546-0832 Fax: 706-369-5068

Health History

Patient Name _____

Today's Date _____

DOB:_____ Age:_____

To help us meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history and will be kept in this office.

When was your last physical? _____

Do you see other physicians? If so, please list:_____

_____

1. Please list all ALLERGIES (FOOD, DRUGS, AND ENVIRONMENT) **[ ] Patient Denies any ALLERGIES**

_____ _____

_____ _____

Please list all serious illnesses, operations & other hospitalizations you have experienced and indicate the year these occurred.

2. PAST MEDICAL HISTORY - Have you ever had the following: **( ) Patient Denies any PMH**

	DATES		DATES		DATES
[ ] Abnormal heart rythm/palpitations		[ ] Diabetes		[ ] Liver disease	
[ ] Anemia		[ ] Diverticulitis		[ ] Macular degeneration	
[ ] Anxiety		[ ] Fibrocystic breast disease		[ ] Menopausal symptoms	
[ ] Arthritis/Type		[ ] GERD/indigestion		[ ] Osteoporosis/osteopenia	
[ ] Asthma		[ ] Glaucoma		[ ] Peptic ulcer disease	
[ ] Atrial fibrillation		[ ] Headaches		[ ] Prostate problems	
[ ] Blood clots DVT/PE		[ ] Heart attack		[ ] Seizures (Type)	
[ ] Cancer (Type)		[ ] Heartburn		[ ] Skin Cancer (Type)	
[ ] Congestive heart failure		[ ] Hemorrhoids		[ ] Thyroid problems	
[ ] COPD/emphysema		[ ] Hepatitis-A,B, or C		[ ] Urinary incontinence	
[ ] Coronary artery disease/angina		[ ] High blood pressure		[ ] Urinary tract infections/ recurrent	
[ ] Dementia/memory loss		[ ] High cholesterol		[ ] Sleep Apnea	
[ ] Depression		[ ] Irritable bowel syndrome		[ ] Migraines	
[ ] Other illness		[ ] Kidney stones			

3. PAST SCREENINGS - When have you had the following:

	DATE	ORDERING PHYSICIAN
[ ] Last bone density exam		
[ ] Last colonoscopy		
[ ] Last mammogram		
[ ] Last pap smear		
[ ] Last prostate exam		

4. PAST SURGICAL HISTORY - Have you ever had the following: **( ) Patient Denies any PSH**

	DATES		DATES		DATES
[ ] Appendix		[ ] Cosmetic (Type)		[ ] Hernia Repair (Type)	
[ ] Back Surgery		[ ] C-Section		[ ] Hysterectomy(Ovaries Removed)	
[ ] Breast Biopsy		[ ] D & C		[ ] Tubal Ligation	
[ ] Cataract		[ ] Gallbladder		[ ] Tonsils / Adenoids	
[ ] Joint Replacement		[ ] Other		[ ] Other	
[ ] Heart Bypass		[ ] Other		[ ] Other	

5. FAMILY HISTORY - Has any blood relative (parents, siblings, maternal/paternal aunts, uncles, grandparents) had any of the following:

	Relationship		Relationship
[ ] Cancer (Type)	_____	[ ] Kidney Problems	_____
_____	_____	[ ] Leg / Lung Blood Clots	_____
[ ] Depression	_____	[ ] Osteoporosis	_____
[ ] Diabetes	_____	[ ] Seizure Disorder	_____
[ ] Elevated Cholesterol	_____	[ ] Stroke	_____
[ ] Genetic Problem	_____	[ ] Thyroid Disease	_____
[ ] Heart Disease	_____	[ ] Other	_____
[ ] Hypertension	_____	[ ] Other	_____

6. MEDICATIONS - Please list all medications you are currently taking (Please continue on back of sheet)

CURRENT MEDICATIONS	DOSAGE	HOW OFTEN PER DAY	PRESCRIBING DOCTOR

7. SOCIAL HISTORY:

Tobacco: Do you use tobacco? [ ] Yes [ ] No [ ] Stopped When started?_____ When stopped? _____
What form of tobacco do/did you use? [ ] cigarettes [ ] cigars [ ] pipe [ ] dip [ ] chew [ ] snuff
Would you be interested in quitting tobacco in the next month? [ ] Yes [ ] No

Alcohol: Do you use alcohol? [ ] Yes [ ] No Describe: _____

Recreational Drugs: [ ] Yes [ ] No [ ] Stopped Describe:_____

Exercise: Do you exercise? [ ] Yes [ ] No
In the past 7 days, how many days did you exercise? _____
On the days you exercised, for how long did you exercise? _____ minutes
How intense was your typical exercise? (choose one)
[ ] Light (like stretching or slow walking) [ ] Heavy (like jogging or swimming)
[ ] Moderate (like brisk walking) [ ] Very heavy (like fast running or stairs)

State or country of birth: _____ Education: (highest degree in school) _____

Occupation: (before retirement) _____ Hobbies: _____

Do you use seat belts? [ ] Yes [ ] No Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Do you have a living will? [ ] Yes [ ] No If yes, please bring in a copy.

Do you have a durable power of attorney? [ ] Yes [ ] No If yes, please bring a copy.

Travel History: Have you traveled out of the country in the past one year? If yes, when and where:

_____

Nutrition: (please answer about the past seven (7) days):

How many servings of fruits and vegetables did you typically eat each day? _____
(1 serving = 1 cup of fresh vegetables, 1/2 cup of cooked vegetables or 1 medium piece of fruit. 1 cup = size of a baseball)

How many servings of high fiber or whole grain foods did you typically eat each day? _____
(1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole grain or high fiber ready-to-eat cereal, 1/2 cup of cooked cereal such as oatmeal , or 1/2 cup of cooked brown rice or whole wheat pasta)

How many servings of fried or high fat foods did you typically eat each day? _____
(Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, donuts, creamy salad dressings and foods made with whole milk, cheese, or mayonnaise)

How many sugar-sweetened (not diet) beverages did you typically consume each day? _____

8. IMMUNIZATIONS:

Tetanus	[ ] Yes	[ ] No	Date: _____	Flu	[ ] Yes	[ ] No	Date: _____
Gardasil	[ ] Yes	[ ] No	Date: _____	Hepatitis A	[ ] Yes	[ ] No	Date: _____
Hepatitis B	[ ] Yes	[ ] No	Date: _____	Pneumovax	[ ] Yes	[ ] No	Date: _____
Shingles	[ ] Yes	[ ] No	Date: _____	Prevnar (Available since 2015)	[ ] Yes	[ ] No	Date: _____

9. REVIEW OF SYSTEMS:

Please circle any of the following symptoms you have had in the last year.

Constitutional:	Fatigue	Unexplained weight loss	Loss of appetite			
Eyes:	Change/vision	Blurred vision				
HENT:	Sinus pain	Headaches	Sore throat	Postnasal drip	Dizziness	Vertigo
Breast:	Tenderness	Masses				
Cardiovascular:	Chest pain	Palpitations	Fainting	Shortness of breath	Lower extremity swelling	
Respiratory:	Shortness of Breath	Cough	Wheezing	Hoarseness	Blood in sputum	
Gastrointestinal:	Painful swallowing	Reflux	Bloating	Nausea/vomiting	Change in bowel habits	
Genitourinary:	Urgency	Frequency	Painful urination	Hematuria	Urinary incontinence	
Integument:	Rash	Itching	New skin lesion	Change in existing skin lesion		
Neurological:	Memory difficulties	Transient weakness	Tremors	Muscular weakness	Tingling/numbness	Incoordination
Musculosketal:	Back pain	Joint pain	Muscle pain	Joint swelling		
Endocrine:	Increased urination	Increased thirst	Hot flashes			
Psychiatric:	Anxiety	Depression	Difficulty sleeping			
Heme-Lymph:	Lymph node enlargement or tenderness					
Allergic-Immu:	Sinus	Allergy	Skin irritation			

Signature of Patient or parent if minor **Date**