



ATHENS AREA
INTERNAL MEDICINE

Johnson | Morel | Herrin

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

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

DATE	ORDERING PHYSICIAN
<input type="checkbox"/> Last bone density exam _____	_____
<input type="checkbox"/> Last colonoscopy _____	_____
<input type="checkbox"/> Last mammogram _____	_____
<input type="checkbox"/> Last pap smear _____	_____
<input type="checkbox"/> Last prostate exam _____	_____

4. PAST SURGICAL HISTORY - Have you ever had the following:

Patient Denies any PSH

DATES		DATES		DATES	
<input type="checkbox"/> Appendix _____	<input type="checkbox"/> Cosmetic (Type) _____	<input type="checkbox"/> Hernia Repair (Type) _____			
<input type="checkbox"/> Back Surgery _____	<input type="checkbox"/> C-Section _____	<input type="checkbox"/> Hysterectomy(Ovaries Removed) _____			
<input type="checkbox"/> Breast Biopsy _____	<input type="checkbox"/> D & C _____	<input type="checkbox"/> Tubal Ligation _____			
<input type="checkbox"/> Cataract _____	<input type="checkbox"/> Gallbladder _____	<input type="checkbox"/> Tonsils / Adenoids _____			
<input type="checkbox"/> Joint Replacement _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Heart Bypass _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____			

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

	Relationship		Relationship
<input type="checkbox"/> Cancer (Type)	_____	<input type="checkbox"/> Kidney Problems	_____
	_____	<input type="checkbox"/> Leg / Lung Blood Clots	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Seizure Disorder	_____
<input type="checkbox"/> Elevated Cholesterol	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Genetic Problem	_____	<input type="checkbox"/> Thyroid Disease	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Hypertension	_____	<input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Flu	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Gardasil	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Pneumovax	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Pprevnar	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____

(Available since 2015)

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
Musculoskeletal:	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