

# Union Internal Medicine Specialties, Ltd.

## Internal Medicine / Pulmonology

### HEALTH HISTORY

NAME \_\_\_\_\_ OCCUPATION \_\_\_\_\_

Date of Birth \_\_\_\_\_

#### PAST ILLNESSES

- Asthma
- Hay Fever
- TB (Tuberculosis)
- Kidney Problems
- Heart Problems
- High Cholesterol
- Rheumatic Fever
- Diabetes
- Stroke
- Cancer – Type \_\_\_\_\_
- Anemia
- Abnormal Pap Results
- Ulcers
- Mental Illness
- Seizures
- Depression
- Back Problems
- Thyroid Disease
- Gall Stones
- Hepatitis- A B C
- Liver Problems
- Bleeding Problems
- Skin Problems
- Alcohol Problems
- Drug Problems
- Hearing Loss
- Sexually Transmitted Disease
- HIV or AIDS
- Headaches
- Vision Problems
- High Blood Pressure
- Irregular Periods
- Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

#### IMMUNIZATIONS

- |                                      | Year  |
|--------------------------------------|-------|
| <input type="checkbox"/> Rubella     | _____ |
| <input type="checkbox"/> Measles     | _____ |
| <input type="checkbox"/> Tetanus     | _____ |
| <input type="checkbox"/> Hepatitis B | _____ |
| <input type="checkbox"/> Pneumovax   | _____ |
| <input type="checkbox"/> Flu Vaccine | _____ |
| <input type="checkbox"/> Other       | _____ |
| _____                                | _____ |
| _____                                | _____ |

#### ALLERGIES

Please check any allergies that you have had and write down the reactions.

- Penicillin \_\_\_\_\_
- Sulfa \_\_\_\_\_
- Aspirin \_\_\_\_\_
- Codeine \_\_\_\_\_
- Bee Stings \_\_\_\_\_
- Foods \_\_\_\_\_
- \_\_\_\_\_
- Other \_\_\_\_\_
- \_\_\_\_\_

ALCOHOL USE: Yes \_\_\_\_\_ No \_\_\_\_\_ Quit \_\_\_\_\_  
Amount \_\_\_\_\_ How Often \_\_\_\_\_

TOBACCO USE: Yes \_\_\_\_\_ No \_\_\_\_\_ Quit \_\_\_\_\_  
Type \_\_\_\_\_ Amount Per Day \_\_\_\_\_

#### SURGERIES

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Appendix     | <input type="checkbox"/> Tonsils         |
| <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Breast          |
| <input type="checkbox"/> Uterus       | <input type="checkbox"/> Fallopian Tubes |
| <input type="checkbox"/> D&C          | <input type="checkbox"/> Ovaries         |
| <input type="checkbox"/> Other _____  |  |

#### HOSPITALIZATIONS

Please list dates and reason for each hospitalization

DATE	REASON
_____	_____
_____	_____
_____	_____

#### MEDICATIONS

Please list any medications you take, both prescription and over-the-counter. Give dosage and how often taken.

DRUG	DOSE	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____