SFIM
San Fernando
INTERNAL MEDICINE .Inc

NEW PATIENT HEALTH HISTORY

Patient Name: _____ **Date:** _____ **DOB:** _____

Reason for today's visit: _____

Are you allergic to any medications? ☐Yes ☐ No If yes, to which medications and what reaction **did you have?** _____

_____

When was your last TDAP vaccine? _____

Please list ALL medication (prescription and non-prescription) that you take:

Medication	Dose (mg/mcg)	Number of times taken daily

Social History

☐ Never used nicotine

☐ Currently nicotine use: Type: ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Smokeless tobacco ☐ e-Cigarettes

Amount / day: _____ Years: _____

☐ Former nicotine use: Type / amount / day: _____ Years: _____ Quit date: _____

☐ Exposed to second-hand smoke/nicotine Amount / day: _____

Consume alcohol: Yes / No Type: _____ Amount/day: _____

Use recreational drugs or any problems misusing prescription medications: Yes / No If Yes, type: _____

Frequency: _____

Consume caffeine: Yes / No If Yes, beverage type: _____

Amount/day: _____

Exercise regularly: Yes / No If Yes, activity type(s): _____

Frequency: _____

Do you wear a seatbelt? Always / Occasionally / Never

Family History

☐ Cancer ☐ Stroke ☐ High blood pressure ☐ Anemia

☐ Sudden death ☐ Diabetes ☐ High cholesterol ☐ Mental illness/Dementia

☐ Bleeding problems ☐ Early heart disease (males under 55, females under 65)

NEW PATIENT HEALTH HISTORY

Medical History

Please fill in date of onset for any conditions you have had in the past and **check box for any conditions that you still have**

Condition	Date of Onset
☐ NONE	_____
☐ Migraine headaches	_____
☐ Seizures or convulsions	_____
☐ Stroke	_____
☐ Glaucoma	_____
☐ Cataracts: Circle: Left Right Both	_____
☐ Recurrent ear infections	_____
☐ Hay fever/allergic nose	_____
☐ Chronic sinusitis	_____
☐ Asthma	_____
☐ Chronic bronchitis	_____
☐ Emphysema	_____
☐ Overactive thyroid	_____
☐ Underactive thyroid	_____
☐ Goiter	_____
☐ Heart murmur	_____
☐ Heart attack	_____
☐ Angina	_____
☐ Enlarged heart	_____
☐ Rheumatic fever	_____
☐ High Blood pressure	_____
☐ Bleeding problems	_____

Condition	Date of Onset
☐ Chronic heartburn	_____
☐ Stomach ulcer	_____
☐ Duodenal ulcer	_____
☐ Hepatitis	_____
☐ Cirrhosis	_____
☐ Gall stones	_____
☐ Colon or bowel trouble	_____
☐ Dysentery or severe diarrhea	_____
☐ Rectal trouble	_____
☐ Diabetes	_____
☐ Breast lump(s)	_____
☐ Skin problems	_____
☐ Hemorrhoids	_____
☐ Urinary incontinence	_____
☐ Recurrent urinary infections	_____
☐ Kidney stones	_____
☐ Other kidney disease	_____
☐ Arthritis	_____
☐ Gout	_____
☐ Varicose veins	_____
☐ Phlebitis or blood clots	_____
☐ Other:	_____

Condition	Date of Onset
☐ Sickle cell Circle: Trait disease	_____
☐ Anemia	_____
☐ Cancer Type:	_____
☐ HIV infections/AIDS	_____
☐ Gonorrhea	_____
☐ Syphilis	_____
☐ Genital herpes infection	_____
☐ Anxiety	_____
☐ Depression	_____
☐ Emotional problems	_____
☐ Nervous breakdown	_____

Women:

☐ Menstrual difficulties	_____
☐ Abnormal pap	_____
☐ Ovarian cyst(s)	_____
☐ Gestational diabetes	_____
# of pregnancies:	_____
# of births:	_____
Date of last mammogram	_____
Date of last pap smear	_____

Men:

☐ Prostate trouble	_____
☐ Erectile dysfunction	_____

Past Surgical History: Please list you past Surgeries/Procedures and year

_____

Have you completed an **Advanced Directive** or **Living Will**? ☐ Yes ☐ No

Reviewed by: _____ MD: _____ Date: _____