

ROSWELL INTERNAL MEDICINE SPECIALISTS

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English - Spanish

FAMILY HISTORY

| | LIVING | DECEASED | IF DECEASED, PLEASE LIST CAUSE |
|-----------|--------------------------|--------------------------|--------------------------------|
| Father | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Mother | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Sibling's | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Children | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

IS THERE ANY FAMILY HISTORY OF

| | YES | NO | WHO? | | YES | NO | WHO? |
|-----------------|--------------------------|--------------------------|-------|----------------|--------------------------|--------------------------|-------|
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Mental Disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Breast Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | |

PERSONAL HABITS

| | YES | NO | IF YES, HOW MUCH/HOW OFTEN? |
|----------------------------|--------------------------|--------------------------|-----------------------------|
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you chew tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you use drugs? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you exercise regularly? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

HAVE YOU HAD ANY

Dexa Scan _____

Colonoscopy _____

Endoscopy _____

FOR WOMEN ONLY

| | |
|---|------------------------------------|
| Menstrual Periods _____ | Pregnancies _____ |
| Age Onset _____ | Live Births _____ Caesarian _____ |
| Date Of Last Period _____ | Premature _____ Miscarriages _____ |
| Difficulty With Periods _____ | Date of last PAP Smear _____ |
| Specify _____ | Age of menopause _____ |
| Do you use birth control pills? _____ | |
| Do you practice self breast examinations? _____ | |
| Lumps or discharge from breasts? _____ | Date of last mammogram _____ |