ROSWELL INTERNAL MEDICINE SPECIALISTS
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English - Spanish

PATIENT MEDICAL HISTORY (PART 1)

Full Name (Print): _____

Date of Birth: _____ Today's Date: _____

Please check NO or YES as applicable, if yes, give a brief description of problem.

NO	YES
☐ Weight change	☐
☐ Appetite change	☐
☐ Fever/Chills	☐
☐ Night Sweats	☐
☐ General Weakness	☐
☐ Dizziness, whirling, Or feeling faint	☐

ENDOCRINE SYSTEM

☐ Heat or Cold Intolerance	☐
☐ Thyroid Problems	☐
☐ History of Neck Surgery or irradiation	☐
☐ Increase in Thirst	☐
☐ Increase in Urination	☐

EYES

☐ Failing Vision/ Blind	☐
☐ Cataracts	☐
☐ Double Vision	☐
☐ Pain	☐
☐ Glasses	☐

EAR, NOSE, THROAT

☐ Difficulty Hearing/Deaf	☐
☐ Ringing in Ears	☐
☐ Nose Bleed	☐
☐ Hoarseness	☐
☐ Sinusitis	☐

GASTROINTESTINAL SYSTEM

☐ Nausea	☐
☐ Vomiting	☐
☐ Vomiting Blood	☐
☐ Difficulty in swallowing	☐
☐ Indigestion/ Heartburn	☐
☐ Abdominal Pain	☐
☐ Abdominal Swelling	☐
☐ Jaundice	☐
☐ Red Blood in Stool	☐

NO	YES
☐ Black Stool	☐
☐ Inability to Control Stool	☐
☐ Diarrhea	☐
☐ Constipation	☐
☐ Hemorrhoids	☐
☐ Hernia	☐
☐ Ulcer Disease History	☐
☐ Gall Bladder Disease History	☐
☐ Pancreatitis History	☐

LUNG

☐ Shortness of Breath	☐
☐ Shortness of Breath on Exertion	☐
☐ Sit up to Breathe	☐
☐ Get up after going to sleep To get breath	☐
☐ Cough now? How long?	☐
☐ Phlegm: Volume, Color, Odor, Viscosity	☐
☐ Cough Blood	☐
☐ Wheezing	☐
☐ Blueness in the Lip or Fingertips	☐
☐ Asthma History	☐
☐ Pneumonia History	☐
☐ History of Tuberculosis or Exposure to Tuberculosis	☐
☐ Skilll Test for Tuberculosis Positive ☐ Negative ☐	☐
☐ Chest X-Ray in last year	☐
☐ History of Respiratory Infections, give frequency	☐

HEART & BLOOD VESSELS

☐ Chest Discomfort	☐
☐ Fainting Spells	☐
☐ Palpitations	☐
☐ Swelling of Ankles	☐
☐ Pain in Legs, Calves, or Feet While walking	☐
☐ Swelling or Pain in Calves	☐

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PATIENT MEDICAL HISTORY (PART 1)

PATIENT MEDICAL HISTORY (PART 2)

HEART & BLOOD VESSELS (continued)

NO	YES
☐ Hypertension History	☐
☐ Heart Murmur	☐
☐ Rheumatic Fever	☐

GU SYSTEM (GENERAL)

☐ Frequency passing Urine	☐
☐ Urgency in passing Urine	☐
☐ Pain in passing Urine	☐
☐ Abnormal Urine Color	☐
☐ Blood in Urine	☐

MALE GENITALIA

☐ Stream Size & Force decreased	☐
☐ Hesitancy	☐
☐ Inability to hold Urine (Stress, Urge, Dribbling) of Urine	☐
☐ History of Renal Disease or Stones	☐
☐ History of STD's	☐

FEMALE GENITALIA

☐ Vaginal Bleeding (not Menstrual)	☐
☐ History of STD's	☐

Last Menstrual Period: _____

NERVOUS SYSTEM

NO	YES
☐ Headaches	☐
☐ Loss of Consciousness	☐
☐ Seizures	☐
☐ Stroke History	☐

BLOOD

☐ Abnormal Bleeding / Bruising	☐
☐ Anemia	☐
☐ Transfusions	☐
☐ Family History of Sickle Cell	☐

HEART & BLOOD VESSELS

☐ Joint Stiffness	☐
☐ Joint Pain	☐
☐ Joint Swelling	☐
☐ Muscle Weakness	☐
☐ Backache	☐
☐ NeckPain	☐

PATIENT MEDICAL HISTORY (PART 2)