Long H. Le, M.D.
Internal Medicine

Name_____ Date_____

MEDICAL HISTORY

Please circle any of the following that you have been diagnosed with, either now or in the past.

1.	Diabetes	7.	Cancer	13.	Previous blood transfusion
2.	High Cholesterol	8.	Thyroid disease	14.	Exposure to TB
3.	High blood pressure	9.	Depression	15.	Kidney problems/Stones
4.	Heart Disease	10.	Anemia	16.	Gout
5.	Stroke	11.	Glaucoma/Cataracts	17.	History of Hepatitis
6.	Arthritis	12.	Asthma/Lung Problems	18.	Sexually transmitted disease

Other: _____
_____

SURGICAL HISTORY

Please circle any operations you have had and fill in the year.

1.	Appendectomy	_____	10.	Hernia repair	_____
2.	Back surgery	_____	11.	Vasectomy	_____
3.	Breast Biopsy	_____	12.	Sinus surgery	_____
4.	Breast implants (silicone)	_____	13.	Knee surgery	_____
5.	Breast implants (saline)	_____	14.	Thyroid surgery	_____
6.	Cataract surgery	_____	15.	Tonsillectomy	_____
7.	Foot surgery	_____	16.	Tubes tied	_____
8.	Gallbladder surgery	_____	17.	Hysterectomy	_____(0 or 1 ovary)
9.	Heart surgery	_____	18.	Hysterectomy	_____(both ovaries)

Other: _____
_____

SOCIAL AND LIFESTYLE HISTORY

Please answer the following questions:

1. What is your occupation?_____

2. How much alcohol do you drink? **None Socially Weekends only 1-2/day >3/day**

3. Do you smoke cigarettes? **Never Quit (when? ____) only very seldom (1-2 cigs/mth)**

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4. How many caffeinated drinks do you drink per day? (do not count de-caffeinated drinks)

None 1-2cups 3-4 cups 5-6cups > 6cups

5. How much planned aerobic exercise of at least 20minutes do you do per week?

None sporadically 1-2 time 3-4 times 5-6 times

6. Are there any major food groups that you do not eat? (vegetarian, ect) _____

7. Do you use intravenous drugs, cocaine, marijuana, or have high-risk behaviors that would put you at risk for HIV? No YES_____

Family History:

Please answer the following: Who in your family have/had (?)

High Blood Pressure	Mother	Father	Siblings	Grandparents	Other relatives
Diabetes	Mother	Father	Siblings	Grandparents	Other relatives
Heart Disease	Mother	Father	Siblings	Grandparents	Other relatives
Stroke	Mother	Father	Siblings	Grandparents	Other relatives
Melanoma	Mother	Father	Siblings	Grandparents	Other relatives
Colon Cancer	Mother	Father	Siblings	Grandparents	Other relatives
Breast Cancer	Mother	Father	Siblings	Grandparents	Other relatives
Ovarian Cancer	Mother	Father	Siblings	Grandparents	Other relatives
Prostate Cancer	Mother	Father	Siblings	Grandparents	Other relatives

What other diseases run in your family?_____

MEDICATION ALLERGIES:

Medication: _____ what type of reactions did you have: _____
Medication: _____ what type of reactions did you have: _____
Medication: _____ what type of reactions did you have: _____
Medication: _____ what type of reactions did you have: _____

MEDICATIONS:

Please list medications that you are currently taking (including birth control pills if you are a woman) and doses:

1._____ 7._____
2._____ 8._____
3._____ 9._____
4._____ 10._____
5._____ 11._____
6._____ 12._____

PREVENTIVE HISTORY:

Please list the last date of the following vaccinations/procedures:

Tetanus_____ Mammogram_____ Bone Density Scan (DEXA)_____
Pneumonia_____ Colonoscopy _____
Flu Shot_____ perform monthly breast exam _____ (women)
Pap smear_____ perform monthly testicular exam_____ (men)