DATE COMPLETED : ____/____/_____ Patient Signature: _____

EAST COUNTY INTERNAL MEDICINE, PA

6050 State Road 70 East, Suite B, Bradenton, FL 34203

NEW PATIENT MEDICAL HISTORY

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:** / /
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous/Referring doctor:	**Date of last physical exam:** / /
Reason for Your Visit Today:	

PAST MEDICAL HISTORY

Check if you have, or have had, any symptoms in the following areas to a significant degree

☐ High Cholesterol	☐ Depression/ Anxiety	☐ Heart Disease
☐ Hypothyroidism	☐ GERD	☐ Heart Attack ☐ Arrhythmias
☐ Diabetes	☐ COPD/ Emphysema	☐ Stent/s ☐ Coronary Heart Disease
☐ Hypertension	☐ Asthma	☐ Heart Bypass Surgery

REVIEW OF SYMPTOMS

Check if you have, or have had, any symptoms in the following areas to a significant degree

☐	Vision Problems	☐	Wheezing	☐	Nausea	☐	History of STD's	☐	Fatigue
☐	Hearing Problems	☐	Asthma/COPD	☐	Vomiting	☐	Anemia	☐	Fever/Sweating
☐	Sinus Trouble	☐	Emphysema	☐	Abdominal Pain	☐	Easy Bruising	☐	Fainting
☐	Hay Fever	☐	Bronchitis	☐	Hepatitis/ Jaundice	☐	Pain in Legs	☐	Seizures
☐	Nosebleeds	☐	TB Exposure	☐	Gallstones	☐	Joint Pain/Stiffness	☐	Headaches
☐	Sore Throat	☐	Chest Pain	☐	Diarrhea	☐	Blood Clot	☐	Numbness/Tingling
☐	Hoarseness	☐	Chest Discomfort	☐	Constipation	☐	Weight Loss/Gain	☐	Anxiety/ Depression
☐	Lumps in Neck	☐	Shortness of Breath	☐	Blood in Stool	☐	Heat/Cold Intolerance	☐	Difficulty Sleeping
☐	Tooth Problems	☐	Lumps in Breast	☐	Frequent Urination	☐	Excessive Hunger	☐	Tremors
☐	Cough	☐	Breast Discharge	☐	Incontinence	☐	Excessive Thirst	☐	Other: _____
☐	Coughing Blood	☐	Trouble Swallowing	☐	Blood in Urine	☐	Weakness	☐	Other: _____

List any medical problems that other doctors have diagnosed

SURGERIES/HOSPITALIZATIONS

Year	Reason	Hospital

OTHER PHYSICIANS OR SPECIALISTS WHO ARE CURRENTLY TREATING YOU

1.	3.
2.	4.

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PRESCRIPTION MEDICATION OR OVER THE COUNTER DRUGS such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

MEDICATION OR FOOD ALLERGIES OR INTOLERANCES

Name the Drug / Food	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Social	Work Status ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled					
	Highest Level of Education:					
	Hobbies:					

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

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DISEASE PREVENTION AND HEALTH MAINTENANCE					
Flu Vaccine	DATE	Mammogram	DATE	Eye Exam	DATE
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		HIV Screening	
Gardasil Vaccine		Chest X-Ray		AB Aneurysm Screen	

***	**Do you have an Advance Directive or Living Will?**	☐ **Yes**	☐ **No**

Patient Mental Health Questionnaire
Over the last 2 weeks, how often have you been bothered by any of the following problems?

	NOT AT ALL	SEVERAL DAYS	MORE THAN Half the Days	Nearly Every Day
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
Felling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
Feeling bad about yourself or that you are a failure or have let yourself/family down	☐ 0	☐ 1	☐ 2	☐ 3
Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that you have been moving around more than usual	☐ 0	☐ 1	☐ 2	☐ 3
Thoughts that you would be better off dead, or of hurting yourself	☐ 0	☐ 1	☐ 2	☐ 3
Add Columns		+	+	
TOTAL				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	☐ NOT DIFFICULT AT ALL	☐ SOMEWHAT DIFFICULT	☐ VERY DIFFICULT	☐ EXTREMELY DIFFICULT

ALCOHOL (AUDIT) QUESTIONS	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4/month	2-3/week	4 times or more/week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10 or more
How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you found that you were notable to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
Has a relative, friend, Doctor or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year