Mercer Internal Medicine, LLC

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Print out this form to complete. Mail, fax, or bring the completed form to the office.

If you have recently completed a medical history form like this, it is fine with us if you just update any changes since your last documentation. We know it is a lot of work to complete forms like this, but it really helps us to give you the best of care when we have your full medical history.

Name:_____ Age:_____ Today's date:_____

Current medical concerns and symptoms (if this is for your MDVIP Wellness Assessment, this section may be left blank):

_____

_____

_____

_____

_____

Previous surgeries and hospitalizations (include dates or year if known): _____

_____

_____

_____

_____

_____

_____

Previous colon cancer screening with colonoscopy or barium enema? Yes No If yes, year done:_____

Name of GI specialist:_____

Circle or list previously diagnosed medical illnesses:

Hypertension	Diabetes
High cholesterol	Hypothyroidism/Hyperthyroidism/Goiter
Glaucoma/Cataract	Coronary disease/Heart attack
Congestive heart failure	Valvular heart disease
Cardiac arrhythmia	Emphysema/Chronic bronchitis
Asthma/Hayfever/Eczema	Peptic ulcers(duodenal/gastric)
GERD/reflux/acid indigestion	Hepatitis (type if known)_____
Stroke	Seizures
Anemia	Bleeding disorder
Clots in legs/lungs (DVT/PE)	Cancer
HIV/AIDS	Tuberculosis
Obesity/Eating disorder	Other illnesses:_____

Current medications (including birth control pills and non-prescription drugs): _____

_____

_____

_____

_____

_____

Drug and Food Allergies: _____

Immunizations received: Tetanus(most recent) _____ Influenza(most recent) _____

Pneumovax_____ Other immunizations: _____

Do you use eyeglasses or contact lenses? Do you use eyeglasses or contact lenses? Yes No

Eye doctor's name:_____

Do you use hearing aides? Yes No

Family History

Have any of your close family members suffered from hypertension, diabetes, heart attacks, stroke, cancer, or tuberculosis? If so, please indicate details of the family medical history below:

Paternal Grandfather (your father's dad): _____

Alive? Yes No, If no, age and cause of death:_____

Paternal Grandmother (your father's mom): _____

Alive? Yes No, If no, age and cause of death:_____

Maternal Grandfather (your mother's dad): _____

Alive? Yes No, If no, age and cause of death:_____

Maternal Grandmother (your mother's mom): _____

Alive? Yes No, If no, age and cause of death:_____

Father: _____

Alive? Yes No, If no, age and cause of death:_____

Mother: _____

Alive? Yes No, If no, age and cause of death:_____

Brother #1: _____

Alive? Yes No, If no, age and cause of death:_____

Brother #2: _____

Alive? Yes No, If no, age and cause of death:_____

Sister #1: _____

Alive? Yes No, If no, age and cause of death:_____

Sister #2: _____

Alive? Yes No, If no, age and cause of death:_____

Son/daughter #1: _____

Alive? Yes No, If no, age and cause of death:_____

Son/daughter #2: _____

Alive? Yes No, If no, age and cause of death:_____

Son/daughter #3: _____

Alive? Yes No, If no, age and cause of death:_____

Social History

Place of birth: _____ **Places where you were raised**: _____

Marital status: Single Married Divorced Widowed Separated Unmarried but in a relationship

Ages of children (if any): _____ _____ _____ _____ _____ _____ _____ _____

Occupation and place of work: _____

_____

Special interests/hobbies: _____

_____

Do you smoke? Yes (average # of packs per day:____ starting age____). Never smoked. Previously smoked but quit in____

Do you drink alcohol? Yes, average # of drinks per week:___. Never or rarely drink.

Do you usually wear your seat belt when in a car? Yes No

Are you at risk for sexually transmitted illnesses? Yes No Not sure Interested in getting tested

Do you have an exercise regimen to help stay physically fit? Yes No If yes, please briefly describe your routine:

_____

Are you on any special type of diet? Yes No If yes, please briefly describe the type of diet:

_____

Do you have an Advance Directive/Living Will? Yes No

Hand dominance: Right handed Left handed Ambidextrous

For men only:

When was your last PSA blood test done? _____

For women only:

Last Pap smear: _____

Last mammogram: _____

Last DEXA bone density study:_____

Number of pregnancies: _____ Number of live deliveries:_____

Birth control method:_____ Last menstrual period:_____

Irregular or heavy periods? _____ Painful periods?_____

Age when periods started:_____ Age when first child was born:_____

If post menopausal, age at menopause: _____ Name of gynecologist:_____

Review of Systems

Have you recently had any of the following symptoms? Please circle those symptoms which pertain to you. In the space on the page, please try to describe the location, duration, and severity of the symptom as well as the circumstances under which the problem seems to occur.

Weight loss/weight gain	Fatigue/weakness
Fever/night sweats	Exercise intolerance
Visual disturbance	Hearing loss/ringing in ears
Nasal congestion/sinus pain	Nose bleed
Throat pain/hoarseness	Swelling in the neck
Breast pain/lump/nipple discharge	Chest pain/palpitations
Cough/sputum	Shortness of breath/wheezing
Abdominal pain/heartburn	Nausea/vomiting/diarrhea
Bloody or black tarry bowel movements	Pain on urination/blood in urine
Difficulty starting or maintaining urine flow	Involuntary leakage of urine
Unusually frequent urination	Discharge from penis or vagina
Concerns about sexual functioning	Joint pain/stiffness
Backache/muscle pain	Cold feet/hands
Cramps in legs with walking	Leg/ankle swelling
Rash/itching	Lumps/bumps/change in mole
Headache/dizziness	Fainting/blackouts
Numbness	Tremors
Confusion/memory difficulties	Localized weakness/paralysis
Nervousness/depression	Insomnia
Heat or cold intolerance	Excessive sweating
Excessive thirst, hunger, or urination	Easy bruising or bleeding
Swollen lymph nodes/glands	

Thanks for completing the Medical History Form! That was a lot of work!!

Mercer Internal Medicine, LLC Reviewed by: GN MY