

# ANCHOR HEALTH CENTERS INTERNAL MEDICINE

Date: \_\_\_\_\_ Pharmacy / Location and Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

## SYMPTOMS -- Check ( / ) symptoms you currently have or have had in the past year:

### General

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of Sleep
- Loss of Weight
- Nervousness
- Numbness
- Sweats

### Gastrointestinal

- Appetite Changes
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood

### Eye/Ear/Nose/Throat

- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty Swallowing
- Double Vision
- Earache
- Ear Discharge
- Hay Fever
- Hoarseness
- Loss of Hearing
- Nosebleeds
- Persistent Cough
- Ringing in Ears
- Sinus Problems
- Vision -- Flashes
- Vision -- Halos

### Men Only

- Breast Lump
- Erection Difficulties
- Lump in Testicles
- Penis Discharge
- Sore on Penis
- Other

### Women Only

- Abnormal Pap Smear
- Bleeding Between Periods
- Breast Lump
- Extreme Menstrual pain
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge
- Other

### Muscle/Joint/Bone

Pain/Weakness/Numbness in:

- Arms  Hips
- Back  Legs
- Feet  Neck
- Hands  Shoulders

### Cardiovascular

- Chest Pain
- High Blood Pressure
- Irregular Heart Beat
- Low Blood Pressure
- Poor Circulation
- Rapid Heart Beat
- Swelling of Ankles
- Varicose Veins

### Skin

- Bruise Easily
- Hives
- Itching
- Change in Moles
- Rash
- Scars
- Sore That Won't Heal

### Urinary

- Blood in Urine
- Frequent Urination
- Lack of Bladder Control
- Painful Urination

### Pulmonary

- Cough
- Wheezing
- Shortness of Breath

Other: \_\_\_\_\_

Date of Last Menstrual Period \_\_\_\_\_

Date of Last Pap Smear \_\_\_\_\_

Date of Last Mammogram \_\_\_\_\_

Are you pregnant? Yes \_\_\_ No \_\_\_

Number of Children \_\_\_\_\_

### Allergies

## CONDITIONS -- Check ( / ) conditions you have now or have had in the past:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Chemical Dependency                | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Polio              |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Chicken Pox                        | <input type="checkbox"/> HIV Positive       | <input type="checkbox"/> Prostate Problem   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Emphysema                          | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Scarlet Fever      |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Epilepsy                           | <input type="checkbox"/> Lung Disease       | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Glaucoma                           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Goiter                             | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea                          | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Gout                               | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Heart Disease                      | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Hepatitis                          | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hernia                             | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cataracts          | <input type="checkbox"/> Herpes                             | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Venereal Disease   |
|   | <input type="checkbox"/> High Blood Pressure (Hypertension) |   |   |

## MEDICATIONS -List all current medications and vitamins including dosage

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY** – Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____

Check ( / ) if blood relatives had any of the following:

- | Disease   | Relationship |
|---|--------------|
| <input type="checkbox"/> Arthritis / Gout       | _____        |
| <input type="checkbox"/> Asthma / Hay Fever     | _____        |
| <input type="checkbox"/> Cancer                 | _____        |
| <input type="checkbox"/> Chemical Dependency    | _____        |
| <input type="checkbox"/> Diabetes               | _____        |
| <input type="checkbox"/> Heart Disease / Stroke | _____        |
| <input type="checkbox"/> High Blood Pressure    | _____        |
| <input type="checkbox"/> Kidney Disease         | _____        |
| <input type="checkbox"/> Tuberculosis           | _____        |
| <input type="checkbox"/> Other                  | _____        |

**PREGNANCY HISTORY**

Birth Year      Sex      Complications, if any

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**HOSPITALIZATIONS**

Year	Hospital	Reason and Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**HEALTH HABITS** – Check ( / ) which, how much and how often:

- |                                   |       |
|-----------------------------------|-------|
| <input type="checkbox"/> Caffeine | _____ |
| <input type="checkbox"/> Tobacco  | _____ |
| <input type="checkbox"/> Alcohol  | _____ |
| <input type="checkbox"/> Drugs    | _____ |
| <input type="checkbox"/> Exercise | _____ |
| <input type="checkbox"/> Other    | _____ |

Have you ever had a blood transfusion?       Yes       No  
 If yes, approximate date \_\_\_\_\_

**SERIOUS ILLNESS / INJURIES**

DATE	OUTCOME
_____	_____
_____	_____
_____	_____
_____	_____

**OCCUPATIONAL CONCERNS** – Check ( / ) if work has exposed you to the following:

- |   |       |
|---|-------|
| <input type="checkbox"/> Stress               | _____ |
| <input type="checkbox"/> Hazardous Substances | _____ |
| <input type="checkbox"/> Heavy Lifting        | _____ |
| <input type="checkbox"/> Other                | _____ |

Your Occupation \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in completing this form.

Signature \_\_\_\_\_

Date \_\_\_\_\_