LAFAYETTE INTERNAL MEDICINE CLINIC

HEALTH HISTORY

(*Confidential*)

Name: _____ Today's Date: _____

Age: _____ Date of Birth: ___/___/___ Date of last physical exam: _____

What is your reason for visit? _____

CHRONIC CONDITIONS Check off conditions you have been diagnosed with in the past and/or are currently receiving treatment for:

□ A. fib (Atrial Fibrillation)	□ Depression	□ Migraines	Other:
□ Alcoholism	□ Diabetes	□ Osteoporosis	□ _____
□ Anemia	□ Epilepsy (Seizures)	□ Pacemaker	
□ Anxiety	□ GERD (Acid Reflux)	□ Pneumonia	□ _____
□ Arthritis	□ Glaucoma	□ Prostate Problem	
□ Asthma	□ Gout	□ Sleep Apnea	□ _____
□ Bleeding Disorders	□ Heart Attack	□ STDs:_____	
□ Cancer: _____	□ Heart Failure	□ Stroke	
_____	□ Hernia: _____	□ Suicide Attempt	
□ Cataracts	□ High Blood Pressure	□ Thyroid Problems	
□ Chemical Dependency	□ High Cholesterol		
□ COPD	□ HIV		
□ Coronary Disease (Heart Stent)	□ Kidney Disease		
	□ Liver Disease		

PREVENTIVE CARE Please specify if and when you have had the following preventive care performed.

Screening Test	Date	Physician/Location	Specify if any abnormalities
Colonoscopy			
Bone Density			
Mammogram			
Pap smear			

SURGERIES

Year	Hospital	Type of Surgery

FAMILY HISTORY

Relation	State of Health (Living/Deceased)	Current Age	Age at Death	Cause of Death	List Medical Problems (Cancers, Heart Disease, etc)
Father					
Mother					
Brothers					
Sisters					

****Please continue on back of form****

PREGNANCY HISTORY

Year	Sex	Complication(s) if any

OCCUPATIONAL CONCERNS

Current Occupation: _____

Check if you're exposed to the following:

□ Stress □ Hazardous Substances □ Heavy Lifting Other: _____

HEALTH HABITS Check which substances you use and how often.

□ Caffeine: _____
□ Drugs: _____
□ Alcohol: _____
□Tobacco: □ Cigarettes □ Cigars □ Chewing Tobacco □ E-Cigarettes
□ How long have you smoked? _____
□ Packs per day: _____
□ Former smoker? How long_____ Quit date _____

Vaccination History: Please specify which, if any, of the following vaccines you have received.

Screening Test	Date
Flu vaccine	
Pneumonia vaccine (Pneumovax 23, Prevnar 13, or Prevnar 20)	
Tetanus or Tdap vaccine	
Shingles vaccine	
Covid-19 vaccine	
RSV vaccine	
Other: MMR, Hepatitis A, B, Meningococcal	

LIST THE PHYSICIANS YOU ARE CURRENTLY SEEING AND THEIR SPECIALTY

_____

_____

_____

_____

_____

_____

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

_____ _____

Signature Date