North Marin Internal Medicine
MARIN HEALTHCARE DISTRICT

Health History

Name
(Last, First, MI): _____ ☐ M ☐ F DOB: ___/___/___

Previous or Referring Doctor:_____ Date of last physical exam: _____

Marital Status					
❑ Single	❑ Married	❑ Separated	❑ Divorced	❑ Widowed	❑ Partnered

Immunization	**Date(s)**	**Immunization**	**Date(s)**	**Immunizations**	**Date(s)**
Tetanus/Diptheria (Td)		Hep A		Gardasil	
Pneumonia		Hep B		Tetanus/Pertussis (Tdap)	
Shingles		Influenza		Others:	

List any medical problems for which you are receiving treatment (<u>Include year of onset</u>)
Example: Diabetes, Hypertension, High Cholesterol, Cancer, Heart Disease, etc.

Procedures or Surgeries

Description	*Year*

Hospitalizations or Previous Serious Illnesses

Description	*Year*

Last Name, First Name: _____

Allergies to Medication	❑ No known allergies
Substance	*Reaction*

Medications *(Including prescription and over the counter)*	❑ No current medications	
Name of Medication	*Dose*	*Frequency*

Have you ever had a blood transfusion? ❑ No ❑ Yes If yes, what year: _____

Health Related Behaviors		
Exercise	What do you do for exercise?	
	How many times per week?	
	How long on average?	
Diet	Do you feel that you are above or below your ideal weight? ❑ Yes ❑ No	If yes, what is your ideal weight? _____
	How many meals do you eat in an average day?	
	Rank your salt intake (High, Medium, Low)	
	Rank your fat intake (High, Medium, Low)	
Empty Calories	How many meals per week do you eat at fast food restaurants (i.e., McDonald's, Taco Bell, IHOP, etc)?	
	Many commonly eaten foods have low nutritional value per calorie. Some examples include candy, ice cream, alcohol, pastries, donuts, soda, milkshakes and fruit juices. How many portions of empty calories do you eat per day?	
Alcohol	Do you drink alcohol? If yes, how many per weekday? _____ Per weekend? _____	❑ Yes ❑ No
	Do you ever drink alcohol before lunchtime?	❑ Yes ❑ No
	Have you considered cutting down?	❑ Yes ❑ No

	Has anyone in your family had a problem with alcohol dependency?	❑ Yes ❑ No
	Are you or anyone in your family concerned about the amount you drink?	❑ Yes ❑ No
	Do you drive after drinking?	❑ Yes ❑ No
Tobacco	Do you use tobacco?	❑ Yes ❑ No
	If yes, what type of product do you use? ☐ Cigarettes____packs/day ☐ Chew _____#/day ☐ Other _____#/day	
	If you use tobacco, how many years have you been smoking or chewing?	
	If you have already quit using tobacco, what year did you quit?	
	If you are still using tobacco, are you considering or would you like more information about quitting?	❑ Yes ❑ No
Drugs	Do you currently use recreational or street drugs?	❑ Yes ❑ No
	If yes, what type(s) are you currently using?	
	Have you ever given yourself street drugs with a needle?	❑ Yes ❑ No
Sex	Are you sexually active?	❑ Yes ❑ No
	If yes, have you had more than one partner in the last year? How many? _____	❑ Yes ❑ No
	Do you have sex with: ☐ Men ☐ Women ☐ Both Men and Women	
	Have you had a sexually transmitted infection (i.e., herpes, Chlamydia, gonorrhea, syphilis, HIV) in the past year?	❑ Yes ❑ No
Personal Safety	Do you have vision or hearing loss?	❑ Yes ❑ No
	Have you experienced more than 1 fall in the past year?	❑ Yes ❑ No
	Do you have an Advanced Directive or Living Will?	❑ Yes ❑ No
	Would you like more information on the preparation of an Advanced Directive or Living Will?	❑ Yes ❑ No
	Do you wear a seat belt?	❑ Yes ❑ No
	Do you have smoke detectors in your home?	❑ Yes ❑ No
	Has anyone beaten, punched or kicked you in your home in the past 6 months?	❑ Yes ❑ No
	Do you feel safe at home?	❑ Yes ❑ No

Family Health History

Relation	*Age*	*Conditions*	*Age at Death*	*Cause of Death*	*Relatives with the following conditions:*		
					Disease		*Relationship*
Father					❑ Arthritis		
Mother					❑ Asthma		
Brothers					❑ Cancer Please list type:		
					❑ Depression		

					❑ Diabetes		
					❑ Heart Disease		
Sisters					❑ Hypertension		
					❑ Kidney Disease		
					❑ Stroke		
					❑ Other:		

Mental Health	
Is stress a major problem for you?	❑ Yes ❑ No
Have you felt sad, blue or depressed over the past 2 weeks?	❑ Yes ❑ No
Do you have any problems sleeping? If yes, describe:	❑ Yes ❑ No
Do you have problems with eating or your appetite? If yes, describe:	❑ Yes ❑ No
Do you feel that you are not enjoying the activities that you used to?	❑ Yes ❑ No
Have you found yourself having trouble concentrating or making decisions?	❑ Yes ❑ No
Have you ever seriously thought about hurting yourself?	❑ Yes ❑ No
Have you even been to a counselor or therapist?	❑ Yes ❑ No

Women Only		
Age at onset of menstruation: ___	Date of last menstruation: _____	Period arrives every _____ days
Do you have heavy periods, irregularity, spotting, pain or discharge?		❑ Yes ❑ No
If yes, describe:		
Are you currently using birth control?	If yes, describe:	❑ Yes ❑ No
Number of pregnancies: _____	Number of live births: _____	
Are you pregnant or breastfeeding?		❑ Yes ❑ No
Have you had a D&C, hysterectomy or Cesarean?		❑ Yes ❑ No
Have you had urinary tract, bladder, kidney or yeast infections in the last year?		❑ Yes ❑ No
Any problems with control of urination? If yes, describe:		❑ Yes ❑ No
Any hot flashes or sweating at night?		❑ Yes ❑ No
Have you experienced any recent breast tenderness, lumps or nipple discharge?		❑ Yes ❑ No

Men Only	
If you get up to urinate during the night, how many times per night? ❑ 1 ❑ 2 – 3 ❑ More than 3	
Do you feel pain or burning with urination?	❑ Yes ❑ No
Has the force of your urination decreased?	❑ Yes ❑ No
Have you had kidney, bladder or prostate infections within the last 12 months?	❑ Yes ❑ No
Do you have problems emptying your bladder completely?	❑ Yes ❑ No

Last Name, First Name: _____

Any difficulty with erection or ejaculation?	❑ Yes ❑ No
Any testicle pain or swelling?	❑ Yes ❑ No
Date of last prostate exam (rectal exam and PSA blood test):	

Screening Tests	**Date**	**Screening Tests**	**Date**
Colonoscopy		General Physical	
Eye Exam		Prostate Exam	
Mammogram		Dexa Scan/Bone Density	
PAP Smear		Other:	

Other Problems / Review of Systems (Circle any problems in each category)

General symptoms: fever, chills, feeling poorly, feeling tired, recent weight gain or loss,	**Respiratory:** shortness of breath, wheezing, cough, breathlessness on exertion, shortness of breath lying flat, wake up w/ shortness of breath	**Endocrine:** hypoglycemic, hot flashes, muscle weakness, deepening of the voice, excessive thirst or urination
Skin: rashes, skin wound, itching, change in a mole	**Musculoskeletal:** joint aches, muscle aches, joint swelling, joint stiffness, back pain, neck pain	**Neurologic:** memory problems, seizures, dizziness, numbness, limb weakness, difficulty walking
Ears, Nose, Throat and Mouth: earache, loss of hearing, nosebleeds, nasal allergies, sore throat, hoarseness	**Gastrointestinal:** abdominal pain, vomiting, constipation, diarrhea, heartburn, black stools	**Psychiatric:** suicidal thoughts, sleep disturbances, anxiety, depression, excessive stress, panic attacks
Eyes: eye pain, red eyes, eyesight problems, discharge from eyes, dry eyes, itchy eyes	**Cardiovascular:** slow heart rate, fast heart rate, chest pain or discomfort, palpitations, pain in calf with walking, lower extremity edema	**Hematologic:** swollen glands, easy bleeding, easy bruising
Female Only: pain with urination, incontinence, pelvic pain, breast lump or tenderness, vaginal discharge, abnormal vaginal bleeding	**Male Only:** pain with urination, trouble starting your stream, dribbling, wake up more than two times in a night to urinate, testicle lump or pain	**Any Other Issues:**

List all other physicians you are currently seeing:

Name	*Specialty*	*City/State*

List all medical devices you are currently using *(Glucometer, Prosthesis, Wheelchair, CPAP, Cane, etc):*

Device	*DME Company Name*