Ryan Internal Medicine
Health History
(Confidential)

Name ____ Today's Date ________

Age _______ Birth date _____________ Date of Last Exam _______________________

What is your reason for visit? ____

Previous Provider? ____

Previous Hospitalizations, Surgeries, Illnesses		
Year	**Hospital**	**Reason**

Medications: list prescription and non-prescription medications that you are taking	**Allergies: to medications or substances and type of reaction**
	Past Immunizations: type and date

Family History						
Relation	**Age**	**State of Health**	**Age of Death**	**Check if your blood relatives have had any of the following**		
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

(**OVER**)

Social History: Please Describe	
Caffeine:	
Tobacco: Current User: Y/ N? If yes, how much and how long?	Former User: Y/ N?
Drugs:	
Alcohol:	
Exercise:	
Work:	
Residence: Alone or With Family?	
Sexually active:	

✓ **Symptoms**: Check symptoms you are currently having or have had in the past:

General
__ Chills
__ Depression
__ Fever
__ Headache
__ Loss of Sleep
__ Numbness
__ Sweats
Other____________

Eyes, Ears, Nose, Throat
__ Difficulty swallowing
__ Double vision
__ Earache
__ Hay Fever
__ Hoarseness
__ Loss of Hearing
__ Ringing in Ears
__ Sinus Problems
Other____________

Pulmonary
__ Shortness of breath
__ Cough
__ Sputum Production
__ Shortness of Breath on Exertion
Other________________

Cardiovascular
__ Chest Pain
__ Shortness of Breath at Night
__ History of Heart Attack
__ Fainting/Dizzy Spells
__ Palpitations
Other__________

Gastrointestinal
__ Indigestion
__ Nausea
__ Vomiting
__ Change in Bowel Habits
__ Constipation
__ Diarrhea
Other__________

Genitourinary
__ Blood in Urine
__ Frequent Urination
__ Lack of Bladder Control
__Men-Lump(s) in Testicles
Other__________

CNS
__ Seizures
__ Stroke
__ Fainting
__ Weakness
__ Numbness
Other__________

Skin
__ Change in mole
__ Rash
__ History of Skin Cancer
Other__________

Muscle/Joint/Bone Pain, Weakness, Numbness
__ Arms
__ Back
__ Feet
__ Hands
__ Hips
__ Legs
__ Neck
__ Shoulder

Women Only
__ Abnormal Pap
__ Bleeding between periods
__ Breast Lump
__ Hot Flashes
__ Nipple Discharge
__ Painful Intercourse
__ Vaginal Discharge
Other___________

Date of menstrual Period __________

Date of last Pap Smear__________

Have you had a Mammogram? ____
Date: ______
Are you pregnant? ____
Number of children? ____

Comments: