South Denver Internal Medicine
A Concierge Medical Practice at Sky Ridge Medical Center
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ADULT HEALTH HISTORY

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Name: **Date:**

Age: **Date of Birth:** **Female** O Male O

Who or how were you referred to our office:

What is the main reason for today's visit?

1. PAST MEDICAL HISTORY

MARK CONDITIONS YOU HAVE OR HAVE HAD

CONDITION	YEAR	CONDITION	YEAR	CONDITION	YEAR
Acid Reflux (GERD)	O	Eczema	O	Mumps	O
Alcoholism	O	Gastritis	O	Osteoarthritis	O
Alzheimers	O	Glaucoma	O	Osteoporosis	O
Anemia	O	Goiter	O	Pap Smear Abnormal	O
Anorexia	O	Gonorrhea	O	Parkinson's	O
Anxiety	O	Gout	O	Pneumonia	O
Arthritis	O	Heart Attack (MI)	O	Polio	O
Asthma	O	Heart Murmur	O	Prostate Cancer	O
Atrial Fibrillation	O	Hemorrhoids	O	Prostate Enlarged	O
Back Pain	O	Hepatitis B	O	Rheumatoid Arthritis	O
Bipolar	O	Hepatitis C	O	Rheumatic Fever	O
Bleeding Disorder	O	Hernia (Hiatal)	O	Seizures (Epilepsy)	O
Blood Clot Leg (DVT)	O	Hernia (Inguinal)	O	Shingles	O
Blood Clot Lung (PE)	O	Herpes	O	Sinusitis	O
Blood Transfusion	O	High Blood Pressure	O	Sleep Apnea	O
Breast Cancer	O	High Cholesterol	O	Stomach Ulcers (PUD)	O
Breast Lump	O	HIV Positive	O	Stroke	O
Bulimia	O	Hypothyroid (low)	O	Syphillis	O
Cataracts	O	Hyperthyroid (high)	O	TB Skin Test -positive	O
Celiac Disease	O	Incontinence-urinary	O	Tuberculosis	O
Chicken Pox	O	Infertility	O	Urinary infections recurrent	O
Cirrohsis	O	Kidney Failure	O	Vertigo	O
COPD/Emphysema	O	Kidney Stones	O	**Other Medical Conditions:**	
Coronary Artery Disease	O	Lung Cancer	O	1.	
Depression	O	Lupus	O	2.	
Diabetes Type I (Child)	O	Measles	O	3.	
Diabetes Type II (Adult)	O	Melanoma	O	4.	
Diverticulitis	O	Migraines	O	5.	

2. PAST SURGERIES

MARK SURGERIES YOU HAVE OR HAVE HAD

SURGERY	YEAR	SURGERY	YEAR	SURGERY	YEAR
Angioplasty (PTCA)	O	Colon Resection	O	Knee Replaced	O
Aortic Valve Replaced	O	Coronary Bypass	O	Lumpectomy	O
Appendectomy	O	Gallbladder (cholecystectomy)	O	Mastectomy	O
Back Surgery-Discectomy	O	Gastric Bypass	O	Mitral Valve Replaced	O
Back Surgery-Fusion	O	Hemorrhoidectomy	O	Pacemaker	O
Bronchoscopy	O	Hernia Repair	O	Parathyroidectomy	O
C-Section	O	Hip Replaced	O	Rotator Cuff Repair	O
Carotid Endarterectomy	O	Hysterectomy - Total	O	Tonsillectomy	O
Carpal Tunnel	O	Hysterectomy- Partial	O	Tubal Ligation	O
Cartaract	O	Knee Arthroscope	O	Vasectomy	O

Physician Reviewed: _____ **Date:** _____

3. MEDICATIONS - LIST ANY MEDICATIONS YOU TAKE INCLUDE HERBS AND VITAMINS

Medications, Vitamins and Herbs	Dose	Times /day

Medications, Vitamins, and Herbs	Dose	Times /day

4. ALLERGIES TO MEDICINES

Name of Medication	List Allergy or Reaction

5. HEALTH MAINTENANCE

	Date
Bone density:	
Colonoscopy:	
Eye exam:	
Mammogram: (women only)	
Pap smear: (women only)	
Pneumonia vaccine:	

6. SOCIAL HISTORY

Work History: Currently working O Retired O	**Current or Former Occupation:**

Married O	Divorced O	Widowed O	Single O

Do you **exercise** on a regular basis?	Yes O		No O
How many days do you exercise per week?			
Type of exercise?			
Do you drink **alcohol** on a regular basis?	Yes O		No O
Number of drinks per week?			
Do you currently use **tobacco**?	Yes O		No O
Year you started smoking?			
Cigarettes?	Yes O	No O	packs/day
Cigars?	Yes O	No O	#/week
Smokeless?	Yes O	No O	per day
Passive smoke?	Yes O	No O	

Have you ever used tobacco?	Yes O	No O
Year you started smoking?		
Year you quit smoking?		
Do you or have you used **illicit drugs?**	Yes O	No O
Does **stress** affect your health?	Yes O	No O

Describe your **diet**? (check all that apply)			
Regular and Healthy	O	Low salt	O
Regular and needs to improve	O	Low carbohydrate	O
Diabetic	O	Gluten free	O
Low cholesterol and fat	O	Vegetarian	O

7. FAMILY HISTORY

Mark if your blood relatives have had any of these conditions

Condition		Relation to you
Alcoholism	O	
Alzheimers	O	
Anemia	O	
Anxiety	O	
Asthma	O	
Bleeding disorder	O	
Breast cancer	O	
Celiac disease	O	
Crohn's disease	O	
Colon cancer	O	
Depression	O	
Diabetes	O	
Heart attack	O	
Heart disease	O	
High blood pressure	O	
High cholesterol	O	
Kidney disease	O	
Lung cancer	O	
Lupus	O	
Melanoma	O	
Migraines	O	
Osteoporosis	O	
Prostate cancer	O	
Rheumatoid arthritis	O	
Stroke	O	
Seizures	O	
Thyroid disease	O	

Patient Name: _____

Physician Reviewed: _____ **Date:** _____