South Denver Internal Medicine
A Concierge Medical Practice
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ADULT HEALTH HISTORY

Name: **Date:**

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

Who or how were you referred to our practice?

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

2. PAST SURGERIES

MARK SURGERIES YOU HAVE OR HAVE HAD

SURGERY	YEAR	SURGERY	YEAR	SURGERY	YEAR
Angioplasty with Stent ☐		Colon Resection ☐		Knee Replaced ☐	
Heart Valve Surgery ☐		Coronary Bypass ☐		Lumpectomy ☐	
Appendectomy ☐		Gallbladder (cholecystectomy) ☐		Mastectomy ☐	
Back Surgery-Discectomy ☐		Gastric Bypass ☐		Mohs for skin cancer ☐	
Back Surgery-Fusion ☐		Hemorrhoidectomy ☐		Pacemaker ☐	
Bronchoscopy ☐		Hernia Repair ☐		Prostate Removed ☐	
C-Section ☐		Hip Replaced ☐		Rotator Cuff Repair ☐	
Carotid Endarterectomy ☐		Hysterectomy & ovaries removed ☐		Tonsillectomy ☐	
Carpal Tunnel ☐		Hysterectomy (uterus removed) ☐		Tubal Ligation ☐	
Cataract ☐		Knee Arthroscope ☐		Vasectomy ☐	

Patient Name: _____ **Date:** _____

3. MEDICATIONS - LIST ANY MEDICATIONS or SUPPLEMENTS YOU TAKE

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	
Calcium Heart Score	
CAT scan Chest (smokers)	
Colonoscopy	
Mammogram (women only)	
Pap smear (women only)	

6. SOCIAL HISTORY

Work History: Currently Working ☐ Retired ☐	**Current or Former Occupation:**

Married ☐ Divorced ☐ Widowed ☐ Single ☐

Do you **exercise** on a regular basis?	Yes ☐	No ☐	
How many days do you exercise per week?			
Type of exercise?			
Do you drink **alcohol** on a regular basis?	Yes ☐	No ☐	
Number of drinks per week?			
Do you **CURRENTLY** use **tobacco**?	Yes ☐	No ☐	
Year you started smoking tobacco?			
Cigarettes?	Yes ☐	No ☐	Packs/day?
Cigars?	Yes ☐	No ☐	#/week?
Chewing Tobacco?	Yes ☐	No ☐	Cans/week
Vaping?	Yes ☐	No ☐	Amount?

Have you smoked tobacco in the PAST?	Yes ☐	No ☐
Year you started smoking?		
Year you quit smoking?		
Do you or have you used **illicit drugs?**	Yes ☐	No ☐
Does **stress** affect your health?	Yes ☐	No ☐

Describe your **diet**? (Check all that apply)

Needs to Improve	☐	Low Cholesterol/Fat	☐
Healthy	☐	Low carbohydrate	☐
Diabetic	☐	Gluten free	☐
Intermittent Fasting	☐	Vegetarian/VEGAN	☐

7. FAMILY HISTORY

Mark if your blood relatives have had any of these conditions

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

Patient Name: _____ **Date:** _____

8. REVIEW OF SYSTEMS

Mark if you CURRENTLY have or have had within the last FEW WEEKS any of the symptoms below.

GENERAL

- ☐ Abnormal bleeding
- ☐ Abnormal bruising
- ☐ Chills
- ☐ Cold intolerance
- ☐ Dizziness
- ☐ Fainting episodes
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat intolerance
- ☐ Insomnia
- ☐ Loss of appetite
- ☐ Lymph node enlarged
- ☐ Night sweats
- ☐ Sleep disturbance
- ☐ Weight gain
- ☐ Weight loss

EYES

- ☐ Blurry vision
- ☐ Double vision
- ☐ Dry eyes
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Floaters
- ☐ Light sensitivity
- ☐ Vision loss

EAR, NOSE AND THROAT

- ☐ Bleeding gums
- ☐ Earache
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Ringing in the ears
- ☐ Seasonal allergies
- ☐ Sore throat
- ☐ Vertigo or room spins

HEART

- ☐ Chest discomfort/pain
- ☐ Difficulty breathing @ night
- ☐ Exercise intolerance
- ☐ Leg cramps with exercise
- ☐ Lightheaded
- ☐ Palpitations/racing heart
- ☐ Short of breath with exercise
- ☐ Swelling (legs or feet)

LUNGS

- ☐ Breathing problems
- ☐ Cough
- ☐ Coughing up blood
- ☐ Coughing up mucus
- ☐ Short of breath
- ☐ Snoring
- ☐ Wheezing

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Black tarry stools
- ☐ Bloating
- ☐ Bloody stools
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas, excessive
- ☐ Heartburn & indigestion
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Swallowing difficulty
- ☐ Swallowing pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Yellow skin/eyes color

ENDOCRINE

- ☐ Skin color has changed
- ☐ Sweating, excessive
- ☐ Thirst, excessive
- ☐ Unusual hair distribution

URINARY

- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Inability to control bladder
- ☐ Inability to empty bladder
- ☐ Frequent urination
- ☐ Lack of sexual drive
- ☐ Nighttime urination
- ☐ Burning/painful urination
- ☐ Urinary urgency
- ☐ Weak urinary stream

MUSCLES AND JOINTS

- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Morning joint stiffness
- ☐ Muscle cramps/pain
- ☐ Muscle weakness

SKIN

- ☐ Change in moles
- ☐ Excessive dry skin
- ☐ Hair loss
- ☐ Hives
- ☐ Itching
- ☐ Nail changes
- ☐ Rash
- ☐ Skin cancer
- ☐ Sores non-healing

NEUROLOGY

- ☐ Concentration difficulty
- ☐ Falls
- ☐ Headaches
- ☐ Numbness or tingling
- ☐ Paralysis
- ☐ Poor balance
- ☐ Seizures
- ☐ Speech difficulty
- ☐ Tremors
- ☐ Weakness

PSYCHIATRY

- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal thoughts
- ☐ Violent thoughts

MEN ONLY

- ☐ Erection problems
- ☐ Lump in testicle
- ☐ Penis discharge
- ☐ Sore on penis

WOMEN ONLY

- ☐ Abnormal PAP
- ☐ Breast lump
- ☐ Breast pain
- ☐ Heavy periods
- ☐ Hot flashes
- ☐ Irregular periods
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Painful periods
- ☐ Pelvic Pain
- ☐ Vaginal discharge
- ☐ Vaginal itching
- ☐ Vaginal sores