LANSDOWNE INTERNAL MEDICINE, LLC
MEDICAL HISTORY FORM

Please answer the following questions to your best ability. Best estimates are fine if you cannot remember specific details. If you are uncomfortable with any question, you do not need to answer it. However, your answers on this form will help your provider understand your medical concerns.

NAME		**AGE**	
How would you rate your general health?	**Excellent**	**Good**	**Fair**	**Poor**
Please list any present health concerns:			

Please list any prescription, non-prescription, supplements and vitamins you are currently taking:

MEDICATION	**DOSE**	**HOW MANY TIMES PER DAY**

Please list any medical problems or illnesses you have had or have currently.

MEDICAL HISTORY/ILLNESS	**YEAR IT FIRST STARTED**	**SPECIALIST**

Please list any allergies or reactions to medications, food allergies or reactions to IV dye

ALLERGY	**TYPE OF REACTION**

Please list any prior surgical procedures

SURGERY	**DATE OF SURGERY**

Please indicate the current status of your immediate family members:

FAMILY HISTORY				
Family Member	Alive	Deceased	Age (now or at death)	Cause of death
Father				
Mother				
Brother(s)				
Sister(s)				
Daughter(s)				
Son(s)				

SOCIAL HISTORY						
Tobacco use	Never	Quit Date:		Current packs/day:		Number of years:
Alcohol use	Never	Social		How many drinks/week:		
Drug use	Never	Have you ever used?		Have you used needles?		
Marital Status	Married	Single	Widowed	Divorced	Separated	
Occupation						
Exercise	Do you currently exercise?			Which activities?	How often?	
Caffeine Intake	None	Coffee cups/day		Tea cups/day	Soda cans/day	
Sexual activity	Are you sexually active?			Have you ever had a sexually transmitted disease?		
Seatbelt use	Never			Sometimes	Always	

Please check if you currently have any of these symptoms:

___ Vision changes
___ Hearing loss
___ Ringing in ears
___ Runny nose
___ Teeth/gum problems
___ Headaches
___ Cough
___ Sore Throat
___ Swallowing problems
___ Wheezing
___ Shortness of breath
___ Chest pain
___ Palpitations
___ Leg swelling

___ Nausea
___ Vomiting
___ Abdominal pain
___ Constipation
___ Diarrhea
___ Blood in stool
___ Black stools
___ Frequent urination
___ Burning with urination
___ Blood in urine
___ Fevers/chills
___ Weight loss
___ Weight gain
___ Lack of appetite

___ Night sweats
___ Joint pains
___ Muscle aches
___ Weakness
___ Numbness
___ Frequent falls
___ Loss of coordination
___ Memory loss
___ Rash
___ Change in moles
___ Easy bruising
___ Unexplained lumps
___ Problems with sleep
___ Depression

___ Anxiety
___ Fatigue
___ Daytime sleepiness
___ Snoring

Any other symptoms:

When were your most recent immunizations and screening tests?

IMMUNIZATIONS					
Tetanus	Flu	Pneumonia	Hepatitis A	Hepatitis B	HPV (Gardasil)
Shingles	Whooping cough	Meningitis	Measles/Mumps/Rubella		

SCREENING TESTS			
Mammogram	Pap smear	Bone density	
Colonoscopy	Prostate	Cholesterol	Diabetes
HIV test			