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Please bring the following questionnaire to your first examination. It will help the physician to know not only about your health but also about your family history.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Are you employed?  Yes  No  Retired If yes, what is your occupation: \_\_\_\_\_

Have you traveled outside the US in the last 5 years? If yes, where? \_\_\_\_\_

**Prescription Medications:** If you have more than six (6) medications, please bring a list to your appointment.

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<b>Non Prescription Medication:</b>	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any illnesses which have occurred in any of your **blood relatives**.

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke            |

Please check any illnesses or conditions **you** have had or been diagnosis.

- |   |                                       |   |  |
|---|---------------------------------------|---|--|
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Blood Clots  | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Diabetes      |
| <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Glaucoma     | <input type="checkbox"/> HIV            | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Jaundice      |
| <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Obesity      | <input type="checkbox"/> Pneumonia      | <input type="checkbox"/> Reflux        |
| <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Sleep Apnea  | <input type="checkbox"/> Stroke/TIA     | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Other(s) _____       |                                       |   |  |

Do you have any known **drug allergies**? If yes, please list **drug name** and **reaction**:

**Non-seasonal allergies** and reactions: (latex, tape, contrast, etc?)

**Surgical History:**

_____	_____
_____	_____
_____	_____

Date of your last colonoscopy: \_\_\_\_\_

Was it normal?  Yes  No

Have you ever taken cortisone-type steroids?  Yes  No

Have you ever had a blood transfusion?  Yes  No

<b>Women Only</b>	
Date of last Pap Smear:	_____
Normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last Mammo:	_____
Normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last Bone Density:	_____
Normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Family History:**

	Living?	Present age or age at death?	Significant health problems or cause of death:
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

			Significant health problems or cause of death:
Brothers	Number Living	_____	_____
	Number Non-Living	_____	_____
Sisters	Number Living	_____	_____
	Number Non-Living	_____	_____
Daughters	Number Living	_____	_____
	Number non-Living	_____	_____
Sons	Number Living	_____	_____
	Number non-Living	_____	_____

**Social History:**

Tobacco use:  Never  Presently  Past History      Packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_  
 When did you quit? \_\_\_\_\_

What type of physical activities do you perform (including exercise, hiking, Yoga, etc.)?  
 \_\_\_\_\_

Do you engage in any other healing or alternative therapies (e.g. acupuncture, massage, hypnosis, etc.)?  
 \_\_\_\_\_

Alcohol use:  Yes  No  Wine  Beer  Spirits      Frequency:  Daily  Weekly  Socially  Occasionally  
 Number of Glasses: \_\_\_\_\_

Caffeine use:  Yes  No  Coffee  Soda      Frequency:  Daily  Weekly  Socially  Occasionally  
 Number of cups: \_\_\_\_\_

Recreational drug use:  Yes  No

Please check the Immunizations you have received:

- |                                      |                                      |                                    |   |
|--------------------------------------|--------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Influenza | <input type="checkbox"/> German Measles (Rubella) |
| <input type="checkbox"/> Measles     | <input type="checkbox"/> Mumps       | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio                    |
| <input type="checkbox"/> Shingles    | <input type="checkbox"/> Tetanus     |                                    |   |

What is your main medical problem now, and how long have you had this problem?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What other medical problem(s) do you want the physician to know about?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other physicians involved in your care:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

In order to support your continuing care Thompson Peak Internal Medicine may share a summary of our findings with the above listed physician.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_