

MGH BEACON HILL INTERNAL MEDICINE
INITIAL HISTORY FORM

Reviewed

By _____

Name _____ Today's Date _____

Date of Birth _____

Where have you received medical care most recently? _____

Please indicate any specific concerns about your health. _____

Your Past Medical History

Alcoholism _____	Emphysema _____	Mitral Valve Prolapse _____
Angina or Heart Attack _____	Hay fever _____	Mental Illness _____
Anorexia/Bulimia _____	Headaches _____	Migraine headaches _____
Arthritis _____	Heart Disease _____	Osteoporosis _____
Back Trouble _____	Heart Murmur _____	Pneumonia _____
Blood Clots _____	HIV Disease _____	Stroke _____
Blood Disorder/Anemia _____	High Blood Pressure _____	Thyroid Problems _____
Blood Transfusion (1980-1985) _____	Intestinal Disorder _____	Tuberculosis _____
Cancer (including skin cancer) _____	Intravenous Drug Use _____	Ulcers/Gastritis _____
Cholesterol Elevation _____	Kidney Disease/Stones _____	
Depression _____	Liver Disease or Hepatitis _____	
Diabetes _____	Loss of Consciousness/Seizures _____	
Drug Abuse _____	Sexually Transmitted Diseases _____	

Other: _____

Please list any other major problems for which you have been under a doctor's care in the past. _____

Surgery: Procedures _____ Dates _____

Preventive Health History

Immunizations/Health Screens

Please list the date of your last:

Flu shot _____	Tetanus Shot _____
Sigmoidoscopy _____	Hepatitis A (Havrix) _____
Eye Exam/Glaucoma _____	Hepatitis B (Series of 3) _____
Dental Exam _____	Measles (MMR) _____
TB Test _____ Result: _____	Pneumococcal _____
Do you use seatbelts? _____	Chicken Pox _____
Do you use sunblock? _____	

Current Medications with Doses

Prescription: _____

Non-Prescriptions (Including Herbs): _____

Allergies to medications: _____

Allergies to food or environment: _____

Family History:

Please list ages and health status (excellent, good, fair, poor, deceased)

Father _____ Siblings _____
Mother _____
Children _____

Please list yes if a blood relative has had any of the following. If yes indicate which relative (e.g., maternal aunt)

Alcoholism _____	High Blood Pressure _____
Heart Disease _____	Kidney Disease/Stones _____
Asthma _____	Mental Illness/Depression _____
Diabetes _____	Thyroid Disease _____
Migraine Headaches _____	Osteoporosis _____
Stroke _____	Ulcer Disease _____
Cancer- Breast _____	Colon _____ Other _____

Gynecological History (Female Patients)

Number of: Pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Age of first period _____

Last Menstrual period _____ Are they monthly _____

What birth control method do you or would you use? _____

Do you have frequent vaginal infections? _____

Age at menopause _____

Are you having symptoms of menopause? _____

Hot flashes _____

Vaginal Dryness _____

Other _____

Last Pap test _____

Last Mammogram _____

Please list yes or no if you have ever had:

Abnormal mammogram _____

Abnormal Pap Smear _____

Year: _____ Diagnosis _____

DES Exposure _____

Endometriosis _____

Uterine Fibroids _____

Hormone Replacement Therapy _____

Life Styles and Health Habits

Do you currently smoke cigarettes? _____ If so, how many packs per day? _____

Have you ever tried to quit? _____ Are you interested in quitting? _____

Do you drink alcohol? _____

Please indicate average number of drinks per week (1 drink=5oz wine) _____

Has drinking ever been a concern for you? _____

How many cups of coffee, tea or cola do you drink per day? _____

Have you ever used recreational or illicit drugs? _____

Do you follow a special diet? _____

How many servings of fruits and vegetables per day do you eat? _____

Do you exercise regularly? _____

Do you have Trouble Sleeping? _____

Does your health make it hard to maintain your daily activities? _____

Social History

Relationship Status: Single _____ Married _____ Divorced _____ Widowed _____
Opposite Sex Partner _____ Same Sex Partner _____

Do you live with others? _____

Children: _____

Are you currently sexually Active? _____ **if yes**, with: _____ Men
_____ Women
_____ Both

Current Employer: _____ Position: _____

Have you ever been in a relationship with a person who hurt or threatened you?

Have you ever been in a relationship with a person whom you have hurt or threatened?

Do you have any beliefs, values or ideas that you want to have your doctor know?

After you have answered all the questions above, is there anything else you would like to discuss today?

Review of Systems

Please list "yes" if you are having any concerns **NOW** about any of the following conditions:

General

Fever _____ Weight Loss _____ Weakness _____ Fatigue _____ Pain _____ Bleeding _____
Trouble Sleeping _____ Lumps _____ Growths _____

Eyes

Vision Problem _____ Redness _____ Excess Tears _____

Ears

Hearing Problem _____ Popping _____ Stiffness _____

Mouth

Tooth Problem _____ Difficulty Chewing _____

Heart and Lungs

Abnormal Heart Beats _____ Cough _____ Snoring _____ Wheezing _____

GI

Difficulty Swallowing _____ Heartburn _____ Diarrhea _____ Constipation _____
Blood in Stool _____ Black Stool _____ Excess Gas _____

GU

Difficulty Urinating _____ Frequent Urination _____ Loss of Urine _____ Sexual Problem _____

Musculoskeletal

Swollen Joint _____ Stiff Joint _____ Back Trouble _____ Neck Trouble _____

Skin

Rash _____ Unusual Mole _____ Acne _____ Itch _____

Neurologic

Numbness _____ Shakiness _____ Difficulty Walking _____

Emotional

Sadness _____ Anxiety _____ Unusual Thoughts _____ Other Emotional Problems _____

Endocrine

Excessive Hunger _____ Excessive Thirst _____ Heat Sensitivity _____ Cold Sensitivity _____

Hematologic

Infection _____ Black and Blue Marks _____

Other Problems: _____