

**MGH BEACON HILL INTERNAL MEDICINE**  
**INTERIM HISTORY FORM**

Reviewed

By \_\_\_\_\_

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

What are your health concerns for this check-up?

\_\_\_\_\_

Have you had any major health or personal problems since your last check-up?

\_\_\_\_\_

Have you made any important changes in your life or health habits since your last check-up?

\_\_\_\_\_

Does your health make it hard to maintain your daily activities? \_\_\_\_\_

**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:** \_\_\_\_\_

Have you ever used recreational or illicit drugs? \_\_\_\_\_

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? \_\_\_\_\_

Are you currently sexually Active? \_\_\_\_\_ if yes, with: \_\_\_\_\_ Men  
\_\_\_\_\_ Women  
\_\_\_\_\_ Both

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?  
\_\_\_\_\_

**Please review the attached Allergy and Medication List for accuracy and make any changes that are necessary.**