NEUSE VALLEY INTERNAL MEDICINE
Health History Report

Questions contained in this questionnaire will be entered into your medical record

Name:	M F	DOB:	PCP: Anderson Peele Rose O'Rourke

Reason for today's visit:

PERSONAL HEALTH HISTORY
Check conditions you have or had in past

☐ High blood pressure/Hypertension	☐ Asthma	☐ Migraines
☐ High Cholesterol	☐ COPD	☐ Depression
☐ Heart Attack	☐ Emphysema	☐ Anxiety
☐ Congestive Heart Failure	☐ Kidney Stones	☐ Psychiatric Illness
☐ Angina	☐ Kidney Disease	☐ Glaucoma
☐ Abnormal Heart Rhythm	☐ Gallstones	☐ Allergies
☐ Stroke	☐ Intestinal Problems	☐ Cancer: Type /Location_____
☐ Diabetes	☐ Reflux Disease	_____
☐ Rheumatoid Arthritis	☐ Liver Disease	Other:_____
☐ Thyroid	☐ Stomach problems	_____

Surgeries	Hospitalizations	Drug Allergies
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS
List ALL medications you currently take including over the counter drugs

Drug name	Strength	Frequency Taken

PREVENTATIVE CARE

Vaccines (year)	Screenings (Year)	
Influenza vaccine_____	Mammogram_____	Pap _____
Tetanus booster _____	Colonoscopy _____	Prostate_____
Shingles vaccine _____	Cholesterol _____	
Pneumonia vaccine_____	Bone Density_____	

SOCIAL HISTORY
Circle answer

Tobacco Use	Alcohol Use	Illicit Drugs	Caffeine
Never / Past / Active	Never / Past / Active	Have you ever used IV drugs	Never / Past / Active
cigarette / cigar / pipe	Liquor / wine / beer	Y N	____ cans / cups per day
dip / chewing	_____drinks per	List any illicit drugs you have	_____
Start_____ Stop_____	day/ week / month	used within the last 5 years	Exercise
Quantity per day_____	AA /Alcohol Rehab	_____	# of days per week_____
		_____	Type:_____

FAMILY HEALTH HISTORY

Please check or list any major illness in your immediate family (Mother, Father, Brother/Sister, Grandparent)

	MOTHER	FATHER	MATERNAL GRANDPARENT	PATERNAL GRANDPARENT	BROTHER/ SISTER
High blood pressure/ Hypertension					
Heart Attack/Failure					
Diabetes					
Stroke					
Thyroid Problems					
Osteoporosis					
Alzheimers/Dementia					
Cancer Type/Location					
Mental Illness					
Other					
Other					

OTHER HEALTH CARE PROVIDERS

Please list all other health care providers that provide care and what conditions they see you for

Provider:_____ Condition_____

Provider:_____ Condition_____

Provider:_____ Condition_____

Provider:_____ Condition_____

Provider:_____ Condition_____

Signature:_____ Date:_____