Primary Care/Internal Medicine
Medical History Form – Please Fill Out Completely

Last Name ______________________________ First Name __________________________________

Birthdate ______________ Age _______ Height _____ Weight_________

Previous primary care provider_____________________ Last physical by primary care

____

How did you hear about us?

____

Any changes to your health in the last year: ☐ Yes ☐ No

If yes, please explain ____

____

Work

☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Type of work performed ______________________________________

Do you have, or are you being treated for any of the following? (Check all that apply)

☐ High Blood Pressure	☐ Pacemaker	☐ Blood clots
☐ Kidney Disease	☐ Bleeding Problems	☐ Asthma
☐ Emphysema	☐ Stomach/colon disease	☐ Cancer
☐ Diabetes	☐ Ulcers	☐ Hepatitis
☐ Seizures	☐ Stroke/TIA	☐ HIV/AIDS
☐ Heart Disease	☐ Neuropathy	☐ Other _________________

If you have diabetes and it is managed by endocrinology, please list the provider and practice name: _______________

____

List all previous surgeries. Use back if needed.

	Procedure	Date (Approximate)	Surgeon
1.			
2.			
3.			
4.			

List any hospitalizations in the past year, include reason for hospitalization, which hospital and approximate length of stay.

1. ____
2. ____
3. ____
4. ____

Please list ALL medications, including non-prescription/supplements. Use back if needed.

Name	Dose	Frequency	Name	Dose	Frequency

1. ______________________________ **5.** ______________________________

2. ______________________________ **6.** ______________________________

3. ______________________________ **7.** ______________________________

4. ______________________________ **8.** ______________________________

Preferred Pharmacy ____ **Phone number (____)_____-______**

Address____

Are you currently receiving treatment at a pain clinic? ☐ Yes ☐ No

If yes, list name and phone number____

Please list ALL medical allergies and reaction. ☐ None Latex Allergy ☐ Yes ☐ No

1. ______________________________ **3.** ______________________________

2. ______________________________ **4.** ______________________________

Do you have a living will? ☐ Yes ☐ No Highest grade completed ____________________

Are you following any kind of diet: ☐ Yes ☐ No If yes, what kind of diet: ____________________

How much caffeine do you drink per day? ____

Stairs in home: ☐ Yes ☐ No Cane: ☐ Yes ☐ No Walker: ☐ Yes ☐ No Wheelchair: ☐ Yes ☐ No

Alcohol use: ☐ Yes ☐ No Number of drinks: _____ day ______week

Tobacco use: ☐ Yes ☐ No _______Cigarettes (pack/day) _______cigars/pipe per day _______dip/chew per day

Family History (Check all that apply)

☐ Birth Defects ☐ Heart Disease ☐ Blood clots/bleeding problems

☐ High Blood Pressure ☐ Kidney Disease ☐ Cancer

☐ Asthma ☐ Stomach/Colon disease ☐ HIV/AIDS

☐ Emphysema ☐ Seizures ☐ Hepatitis

☐ Diabetes ☐ Stroke ☐ Other ____________________

Care Team

Please list any other providers who are part of your care team:

Provider and/or Practice Name Specialty

1. ______________________________ ______________________________

2. ______________________________ ______________________________

3. ______________________________ ______________________________

4. ______________________________ ______________________________

5. ______________________________ ______________________________

FACULTY
PHYSICIANS
KNOXVILLE

Women Only

Are you pregnant, or is there any change that you might be pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Number of pregnancies _______ Number of miscarriages ______

Form of Birth Control ____

Any problems associated with your menstrual cycle? ☐ Yes ☐ No Date of last menstrual cycle: ___________________

Are your periods regular? ☐ Yes ☐ No Date of onset of menstrual cycle: _______________

Do you complete self-breast exams? ☐ Yes ☐ No Date of onset of menopause:

____

Review of Systems – Have you had an RECENT problems with any of the following?

Constitutional	**Yes**	**No**
Recent Fever	☐	☐
Night Sweats	☐	☐
Weight Gain	☐	☐
Weight Loss	☐	☐
Exercise Intolerance	☐	☐

Eyes	**Yes**	**No**
Dry Eyes	☐	☐
Irritation	☐	☐
Vision Change	☐	☐

ENMT	**Yes**	**No**
Difficulty Hearing	☐	☐
Ear Pain	☐	☐
Frequent Nose Bleeds	☐	☐
Nose/Sinus Problem	☐	☐
Sore Throat	☐	☐
Bleeding Gums	☐	☐
Snoring	☐	☐
Dry Mouth	☐	☐
Mouth Ulcers	☐	☐
Oral Abnormalities	☐	☐
Teeth Problems	☐	☐

Cardiovascular	**Yes**	**No**
Chest Pain at rest	☐	☐
Chest pain with exertion	☐	☐
Arm pain on exertion	☐	☐
Short of breath - walking	☐	☐
- lying down	☐	☐
Heart Palpitations	☐	☐

Genitourinary	**Yes**	**No**
Urinary Incontinence	☐	☐
Difficulty Urinating	☐	☐
Blood in Urine	☐	☐
Urinary Frequency	☐	☐
Incomplete Emptying	☐	☐

Musculoskeletal	**Yes**	**No**
Muscle Aches	☐	☐
Muscle Weakness	☐	☐
Joint Pain	☐	☐
Back Pain	☐	☐
Extremity Swelling	☐	☐

Integumentary	**Yes**	**No**
Abnormal mole/lesion	☐	☐
Jaundice	☐	☐
Rash	☐	☐
Itching	☐	☐
Dry skin	☐	☐

Neurologic	**Yes**	**No**
Loss of consciousness	☐	☐
Weakness	☐	☐
Numbness	☐	☐
Seizures	☐	☐
Dizziness	☐	☐
Headaches	☐	☐
Restless Legs	☐	☐

Psychiatric	**Yes**	**No**
Depression	☐	☐

Endocrine	**Yes**	**No**
Fatigue	☐	☐
Increased Thirst	☐	☐
Hair Loss	☐	☐
Increased hair growth	☐	☐
Cold Intolerance	☐	☐

Allergic/Immunologic		
Runny Nose	☐	☐
Sinus Pressure	☐	☐
Itching	☐	☐
Hives	☐	☐
Frequent Sneezing	☐	☐

Notes:

Sleep Disturbances	☐	☐
Safe in Relationship	☐	☐
Alcohol Abuse	☐	☐

Gastrointestinal	**Yes**	**No**
Abdominal Pain	☐	☐
Vomiting	☐	☐
Vomiting blood	☐	☐
Change in appetite	☐	☐
Black/tarry stool	☐	☐
Diarrhea	☐	☐

Hematologic/ Lymphatic	**Yes**	**No**
Swollen Glands	☐	☐
Easy Bruising	☐	☐
Excessive bleeding	☐	☐

Signature____Date ____________________