OLYMPIC
INTERNAL MEDICINE, INC. P.S.

MEDICAL HISTORY

PLEASE COMPLETE WITH BLACK INK ONLY Date: _____

Confidential Record: Information here will not be released unless you have authorized us to do so.

Last Name: First Name: Middle:

Date of Birth:

FAMILY HISTORY:		**If Living**		**If Deceased**	
		Age	Health	Age of Death	Cause of Death
Father					
Mother					
Brother/Sister	*(Circle Sex)*				
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughter	*(Circle Sex)*				
	M F				
	M F				
	M F				
	M F				
	M F				

FAMILY HISTORY:

Check if any blood relative has had any of the following and enter relationship:

	Yes	No	Relative:		Yes	No	Relative:		Yes	No	Relative:
Stroke	❑	❑		Migraine	❑	❑		Goiter	❑	❑	
Cancer	❑	❑		Asthma	❑	❑		Arthritis	❑	❑	
High Blood Pressure	❑	❑		Hay Fever	❑	❑		Colitis	❑	❑	
Tuberculosis	❑	❑		Bleeding Tendency	❑	❑		Mental Illness	❑	❑	
Diabetes	❑	❑		Heart Attack	❑	❑		Gout	❑	❑	
Leukemia	❑	❑		Stomach Ulcers	❑	❑		Rheumatic Heart	❑	❑	
Epilepsy	❑	❑		Kidney Disease	❑	❑		Osteoporosis	❑	❑	
Suicide	❑	❑		Congenital Heart	❑	❑					

PAST HISTORY (PERSONAL)

Have you had any of the following illnesses?

	Yes	No		Yes	No	Operations: List and indicate approximate year
Hypertension	❑	❑				
Rheumatic Fever	❑	❑	Cancer	❑	❑	
Angina Pectoris	❑	❑	Osteoporosis	❑	❑	
Heart Attack	❑	❑	Frequent Kidney Infection	❑	❑	
Other Heart Disease	❑	❑	Frequent Bladder Infection	❑	❑	
Anemia	❑	❑	Nervous Breakdown	❑	❑	
Kidney Disease	❑	❑	Thyroid Disease	❑	❑	**Ever had any transfusions?_____Date_____**
Gout	❑	❑	Stomach Ulcers	❑	❑	
Hay Fever	❑	❑	Gallbladder Disease	❑	❑	**Hospitalizations (other than operations):**
Asthma	❑	❑	Jaundice	❑	❑	**List reasons and approximate dates.**
Frequent Lung Infection	❑	❑	Hepatitis	❑	❑	
Emphysema	❑	❑	Colitis	❑	❑	
Diabetes	❑	❑	Arthritis	❑	❑	
Migraine Headache	❑	❑	Other _____	❑	❑	

PAST HISTORY (continued)

MEDICATIONS:

Please list all medicines, prescription or non-prescriptions:
****Include DOSAGE & DIRECTIONS**

Are you allergic to any medication? Yes ❑ No ❑
If yes, please list medications and the reaction to them.

Serious Injuries (this includes fractures) other than above:

Are you being treated by any other health care professionals? Yes ❑ No ❑
If yes, please list their names:

PERSONAL HABITS

1. I use tobacco. Yes ❑ No ❑ Never ❑
   ❑ Smoke:_____ Number of cigarettes per day
   ❑ Chew
   Age started _____ Age stopped _____
2. Do you drink alcohol?
   ❑ Daily ❑ Weekly ❑ Monthly ❑ Never
   Type of alcohol _____
3. Do you use recreational drugs? Yes❑ No❑ Never❑
4. Do you use caffeine products?
   ❑Coffee ❑Soda ❑Tea
5. Do you use seatbelts?
   ❑Always ❑Occasionally ❑Never

OCCUPATIONAL

	Yes	No
Are you presently employed?	❑	❑
Does your work involve unusual work, exposure to dust, noise, radioactivity, asbestos, etc.?	❑	❑
Do you have more than one job?	❑	❑
Do you work more than 60 hour weeks?	❑	❑
Do you get along well with your fellow employees and/or supervisor?	❑	❑
Are you unable to perform any work because of disability?	❑	❑
Are you retired?	❑	❑
If retired, have you had difficulty adjusting to retirement?	❑	❑

MARITAL/FAMILY

	Yes	No
Have you been married more than one time?	❑	❑
Has there been a recent change in marital status?	❑	❑
Are there any problems with your married life?	❑	❑
Do you have any sexual problems?	❑	❑
Is your present home life causing unhappiness?	❑	❑
Have there been any deaths in your family or among close friends in the past year or two?	❑	❑
Does anyone in your family have a serious illness or disability?	❑	❑

SOCIAL HISTORY

	Yes	No
Have you recently lived or traveled outside the U.S.?	❑	❑
Did you complete high school education?	❑	❑
Did you attend and/or complete college?	❑	❑
Did you serve in any branch of the Military?	❑	❑
If so were you discharged?	❑	❑
Years served _____ Status _____		
Have you been denied life or health insurance?	❑	❑
Do you eat less than three meals a day?	❑	❑
Do you have special food customs or restrictions?	❑	❑
Have you ever been treated for a drinking problem?	❑	❑
Are you able to exercise three or more times a week?	❑	❑

Review of Systems:

A. Health Maintenance

Immunization : Date of most recent		Test: Check if abnormal	Date
❑ Measles:		❑ Pap	
❑ Smallpox		❑ Mammogram	
❑ Polio		❑ Colonoscopy/Sigmoid	
❑ Tetanus		❑ EKG	
❑ Hepatitis A/B		❑ Chest X-Ray	
❑ Flu		❑ PSA	
❑ Pneumovax		❑ Dexa/bone density	
❑ Prevnar 13		❑ TB Skin Test	
❑ Zostavax		❑ Cholesterol	
❑ Shingrix			

B. General	**Yes**	**No**
Do you worry a lot about your health?	❑	❑
Do you usually feel tired or worn out?	❑	❑
Do you feel depressed a lot of the time?	❑	❑
Have you recently noticed that heat or warm weather bothers you?	❑	❑
Have you recently been drinking more water or fluids?	❑	❑
Has there been any unusual weight gain or loss recently?	❑	❑

C. Skin		
Have you noticed:	**Yes**	**No**
any change in the color of your skin?	❑	❑
any skin rashes or itching?	❑	❑
unusually dry skin?	❑	❑
any growth on your skin that bothers you?	❑	❑
any sores or wounds that do not heal?	❑	❑
any change in color or size of warts?	❑	❑

D. Eyes	**Yes**	**No**
Have you had:		
any pain in your eyes?	❑	❑
glaucoma?	❑	❑
blurry vision?	❑	❑
halos around lights?	❑	❑
change in vision?	❑	❑

E. ENT	**Yes**	**No**
Do you have:		
any trouble hearing?	❑	❑
ringing or buzzing in your ears?	❑	❑
earaches or discharge from your ears?	❑	❑
a lot of nasal stuffiness?	❑	❑
drainage down the back of your throat?	❑	❑
frequent or severe nosebleeds?	❑	❑
a lump in your throat?	❑	❑
a sore tongue or mouth?	❑	❑
bleeding gums?	❑	❑

F. Respiratory	**Yes**	**No**
Do you have:	❑	❑
frequent chest colds?	❑	❑
a constant or bothersome cough?	❑	❑
coughing up blood?	❑	❑
sputum or phlegm between colds?	❑	❑
difficulty breathing?	❑	❑
Have you noticed any wheezing or whistling in your chest?	❑	❑

G. Cardiovascular	**Yes**	**No**
Do you have pain, tightness or pressure in the front of your chest?	❑	❑
If yes, is it when walking fast, working hard or when excited?	❑	❑
Have you ever been told that your electrocardiogram was abnormal?	❑	❑
Do you have swelling of your feet or ankles?	❑	❑
Does your heart ever beat fast or irregular?	❑	❑
Do you have cramps in the calf muscles when you walk?	❑	❑
Do you ever awaken at night with severe difficulty breathing?	❑	❑

H. Gastrointestinal	**Yes**	**No**
Have you recently had any changes in your eating habits?	❑	❑
Are there any special foods that cause you to be upset or have stomach pains, nausea, etc?	❑	❑
Do you tend to burp a lot?	❑	❑
Have you recently noted any trouble swallowing?	❑	❑
Do you have a lot of indigestion or heartburn?	❑	❑
Have you ever vomited blood?	❑	❑
Are you bothered with constipation?	❑	❑
Do you have frequent loose stool or diarrhea?	❑	❑
Do you pass a lot of gas?	❑	❑
Do you have a poor appetite?	❑	❑
Do you ever awaken at night with the feeling of fullness underneath your breast bone?	❑	❑
Have you ever passed blood from your rectum?	❑	❑
Have you ever had black or tarry stools?	❑	❑
Have you noticed any recent changes in your bowel movements?	❑	❑
Do you take laxatives regularly?	❑	❑
Do you have frequent nausea and/or vomiting?	❑	❑

I. GENITOURINARY		
Do you have:		
anything wrong with your genitals?	❑	❑
burning or pain when you urinate?	❑	❑
to pass water frequently?	❑	❑
to pass more water than you use to?	❑	❑
to get up at night to urinate?	❑	❑
trouble with losing urine when you cough or sneeze?	❑	❑
a problem dribbling urine?	❑	❑
Have you ever passed blood in your urine?	❑	❑
Have you had an operation to prevent pregnancy?	❑	❑
(Vasectomy or sterilization, such as tubal ligation)	❑	❑
Men, do you have prostate gland trouble?	❑	❑
Have you ever had any sexually transmitted disease?	❑	❑

What type? _____

Notes: _____

Review of Systems (continued)

J. Musculoskeletal	Yes	No
Do you have a problem with back pain?	❑	❑
Do you have pain in your legs or feet?	❑	❑
Does your back pain interfere with your work or activities?	❑	❑
Do you have joint pain or stiffness?	❑	❑
Do you have trouble walking or using your hip or knee joints?	❑	❑

K. Central Nervous System	Yes	No
Do you have frequent or severe headaches?	❑	❑
Do you often have spells of dizziness or faintness or lightheadedness?	❑	❑
Have you ever seen double?	❑	❑
Do you sometimes lose track of what happens around you for a short time?	❑	❑
Do you sometimes lose the ability to speak for a few seconds?	❑	❑
Have you recently fainted, blacked out or lost consciousness?	❑	❑
Do you have trouble remembering recent events?	❑	❑
Have you ever had convulsions or fits?	❑	❑
Do you have numbness or tingling in in your head, arms or legs?	❑	❑
Do you consider yourself a nervous person?	❑	❑
Do you cry a lot for no reason?	❑	❑
Have you ever had an urge to commit suicide?	❑	❑
Do you ever hear voices or see people when no one is around?	❑	❑
Do you ever have a feeling that someone is trying to harm you?	❑	❑

L. Women Only	Yes	No
What age did you start menstrual cycles?	❑	❑
Are your menstrual cycles irregular?	❑	❑
Are your periods less frequent than every four weeks?	❑	❑
Are your periods more frequent than every four weeks?	❑	❑
Do you use more than 10 pads or have to use a super size pad or tampon for your periods?	❑	❑
Do you pass clots with your period?	❑	❑
Do you become bloated or gain weight just before your periods?	❑	❑
Have you gone through menopause?	❑	❑
What age did you complete menopause?	❑	❑
Do you have hot flashes?	❑	❑
Do you have a poor libido?	❑	❑
Did you have sexual intercourse before age 16?	❑	❑
Did you have more than 5 sexual partners in your lifetime?	❑	❑
Did your mother use DES hormones while pregnant with you?	❑	❑
Did you breastfeed any of your children?	❑	❑
Have you had any abortions or miscarriages?	❑	❑
Have you had any lumps in your breasts?	❑	❑
Have you had any discharge from your nipples?	❑	❑
Have you ever used an intrauterine device (IUD)?	❑	❑
Have you ever used other birth control measures?	❑	❑

ADDITIONAL COMMENTS: