Morgan Hill Internal Medicine

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INITIAL VISIT QUESTIONNAIRE

NAME: _____ DOB: _____ SEX: M / F

Reason for this visit:

Past Medical History:

_____ Hypertension	_____ Bronchial Asthma / COPD	Other: _____
_____ Diabetes	_____ Joint Problems (back / other)	_____
_____ High Cholesterol	_____ Thyroid Disorders	_____
_____ Heart Disease	_____ Stroke	_____
_____ Heart Murmur	_____ Chronic Headache	_____
_____ Kidney Disease		_____
_____ Peptic Ulcer / Reflux		_____

Past Surgical History:

_____ Gall Bladder Removal	_____ Heart Surgery	Joint Surgery _____
_____ Appendix Removal	_____ Angioplasty	_____
_____ Kidney Stone Removal	_____ Hysterectomy	_____
_____ Tonsils Removal	_____ Prostate Surgery	_____

Allergies: _____

Current Medications with strength:
(or just provide medication list copy)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Test: (Last Date) _____ Colonoscopy _____ Blood Tests

Female: _____ Pap _____ Mammogram

Social History: Tobacco smoking: Yes / No If yes, how many packs per day _____ Occupation: _____

Alcohol: Yes / No If yes, regular / occasional Other substance abuse: Yes / No

If yes, specify _____

Interested in quitting smoking /alcohol - Yes / No / N/A

Regular fitness activity - Walking / Hiking / Running / Swimming / Cycling / Mountain Biking / Yoga / Group Exercise / Gym / Weight Lifting (Strength training) Other _____

Family History: Hypertension: Y / N Heart Disease Y / N

Diabetes: Y / N Cancer: If yes, specify _____

Are you intrested in future primary care office visit: Yes / No / Maybe

Thank you for completing this form.