Aegis Medical Center

Internal Medicine

Name: _____ Date of Birth: _____
Today's Date: _____

Allergies

Any New Allergies since last Visit? _____

Health Maintenance Screening Test History

Colonoscopy	Date:	Facility/ Provider:	Abnormal Results? Y/N
Mammogram	Date:	Facility/ Provider:	Abnormal Results? Y/N
Pap Smear	Date:	Facility/ Provider:	Abnormal Results? Y/N
Bone Density	Date:	Facility/ Provider:	Abnormal Results? Y/N

Vaccination History

Last Tetanus Booster or TDAP:	Last Pneumovax:
Last Flu Vaccine:	Last Prevnar:
Last Shingles Vaccine:	

Surgeries

Any New Surgeries since last visit? _____

Women's Health History

Date of last Menstrual Cycle:	Age of First menstruation:
Total number of Pregnancies:	Age of Menopause:
Pregnancy Complication:	Number of Live births:

Personal Medical History

Any new Problems since last visit? _____

Family Medical History

Any Changes since last visit? _____

Other Health Issues

Cognitive Functional Status:

	Yes	No
Are you worried about your Memory?		
How often has confusion or memory loss interfered with your ability to work?		
During the past 30 days how often has a family member provided care/ assistance for you because confusion or memory loss?		
Do you have difficulty getting out of a chair or care without assistance?		
Do you use a cane or walker?		
Do you have problems with hearing?		
Do you have problems with vision?		
In the last 12 months have you fallen? If yes how many times?		
Were you injured as a result of the fall?		
Do you have any problems with your ability to speak, hear or see?		

Depression Screening

Over the past two weeks, how often have you been bothered by any of the following problems?

	Yes	No
Little Interest or pleasure in doing things?		
Feeling down, depressed or hopeless?		
Would you rather be alone than with others?		
Do you feel you have difficulty making friends, even when trying to do so?		

Social

Tobacco Use:	Smoke Cigarettes? Y N
Current Packs/Day: # of Years:	Past: Quite Date: Packs/Day:
Other Tobacco:	
Advance Directive? Do you have a living will? Health Care Power of Attorney?	Yes or No
Alcohol/ Drug Use:	Do you drink Alcohol? Y N How many per day:
Caffeine Use:	Do you drink Caffeine? Y N How many per day:
Do you Exercise?	If yes, What kind of exercise: If so how many days a week:
Do you use marijuana or recreational drug? Y N	Have you ever used needles to inject drugs? Y N
Have you ever taken someone else's drugs? Y N	