Charleston Internal Medicine, Inc.
New Patient Health History

Name: _____ **Date of Birth: ____/____/____**

Allergies

Are you allergic to any medication(s)? If yes, list the medication and the allergic reaction.

_____

Do you have any food or environmental allergies? If yes, list the substance and the allergic reaction.

_____

Patient Medical History

Have you been diagnosed with any of the following conditions?

◯ Anxiety
◯ Arthritis-Type_____
◯ Asthma
◯ Cancer-Type_____
◯ Congestive Heart Failure
◯ COPD
◯ Coronary Artery Disease
◯ Depression
◯ Diabetes-Type _____
◯ Elevated Cholesterol
◯ Heart Disease
◯ High Blood Pressure
◯ Osteoporosis
◯ Stroke
◯ Thyroid Disease-Type_____
◯ Other_____
◯ Other_____

Surgical History

Have you had any surgeries or procedures?

	Date		Date		Date
◯ Appendectomy	_____	◯ Heart Surgery	_____	◯ Orthopedic	_____
◯ Breast	_____	◯ Hysterectomy	_____	◯ Prostate	_____
◯ Cataract	_____	◯ Laparoscopy	_____	◯ Thyroid	_____
◯ Gallbladder	_____	◯ Lesion Removal	_____	◯ Tonsillectomy	_____

◯ Other_____
◯ Other_____

Family Medical History

Have any of your family members Mother, Father, Brother, Sister, Maternal or Paternal Grandparents, Aunt, Uncle been diagnosed with the following? List age the relative was diagnosed.

	Relative	Age		Relative	Age
◯ Cancer-Type_____	_____	____	◯ Hypertension	_____	____
◯ Diabetes-Type_____	_____	____	◯ Stroke	_____	
____ ◯ Thyroid- Type_____	_____	____	◯ Heart Disease	_____	____

◯ Other_____
◯ Other_____

Screening History
Have you had a Colonoscopy? **Yes/No** If yes, what was the date of your last Colonoscopy? ___/___/___

Social History
Have you ever used tobacco products?

	Daily Amount Used	**Age Started**	**Age Stopped**
◯ Cigarette	_____	_____	_____
◯ Smokeless tobacco	_____	_____	_____

Vaccine History
Have you had the following vaccines? If yes, list date the vaccine was received.

	Date Received
◯ Tdap or Adacel (Tetanus, diphtheria, pertussis)	_____
◯ Prevnar 13 (Pneumonia 13)	_____
◯ Pneumococcal 23	_____
◯ Influenza	_____

Have you seen any specialist within the last 12 months? If yes, list the provider's name and specialty.
_____

Medication History
Please bring all prescription, over the counter, vitamins/supplement bottles to your visit that you are currently taking. If you do not bring the medication bottles you may be asked to reschedule your office visit.

I attest the above information was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____/_____/_____
Signature of patient or legal guardian ***Date***