Specialists in Internal Medicine, P.A.

2800 Campus Drive – Suite 44, Plymouth, MN 55441

Date: _____/_____/_____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Appointment Date: _____/_____/_____
Date of Birth: _____/_____/_____ Age: _____

Do you have medical records in the Allina Health Care System? ..... Yes or No
Name of previous medical clinic: _____ Phone: _____
Are you followed by any other providers? (Cardiologists/Urologists/Dermatologists, etc) _____
_____ _____ _____ _____

MEDICAL HISTORY

Allergies: (Medications / Latex) & Reaction

_____Reaction:_____ _____Reaction:_____
_____Reaction:_____ _____Reaction:_____

Current/Past Medical Conditions	Hospitalizations/Surgeries	Date
_____	_____	____/_____/_____
_____	_____	____/_____/_____
_____	_____	____/_____/_____
_____	_____	____/_____/_____
_____	_____	____/_____/_____

Medications: (current prescriptions and over the counter)

Medication Name	Strength / Dose	Frequency	Prescribed By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

1. Do you smoke, use tobacco or vape? …… Yes No
   If yes, how many years? _____ # Pack/year: _____ Date quit smoking: _____/_____/_____
2. Do you drink alcohol? …… Yes No
   If yes, how many beverages per day? _____ per week: _____
3. Do you drink caffeine? …… Yes No
   If yes, how much per day? _____

SOCIAL HISTORY cont'd

4. Do you use any recreational drugs? …….. Yes No
5. Do you exercise? …….. Yes No
   Active Lifestyle _____
   Moderate Intensity _____
   High Intensity _____
6. Do you ever feel down or depressed? ……. Yes No

Prevention History

1. Have you ever had a colonoscopy? …… Yes No
   If yes, when: _____/_____/____ Where was your procedure? _____
2. Date of last Mammogram: _____/_____/_____ Where: _____
3. Date of last Bone Density test: _____/_____/_____ Where: _____

FAMILY HISTORY

Please indicate any medical conditions in family members (e.g. diabetes, heart disease high blood pressure, cancer (breast/colon, other), lung disease (emphysema/asthma), kidney disease, stroke, migraines/headaches, arthritis, bleeding issues, mental illness, etc.

	Number of	Deceased	Living	Age or Age at Death		Medical Illness or Cause of Death
Father						
Mother						
Brothers						
Sisters						

Other family history of illness (diabetes, heart disease, cancer, osteoporosis, stroke):

_____

_____