CAIRO INTERNAL MEDICINE
A Division of Archbold Medical Group

PATIENT HISTORY

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held confidential and is released only with your written consent.

Please bring any medications that you are currently taking.

Name: _____ Date of Birth: _____

ALLERGIES:
Are you allergic to latex? ❑ Yes ❑ No Are you allergic to any medications? ❑ Yes ❑ No
If yes, please list with reaction: _____

PAST MEDICAL HISTORY:
Have you had problems in the past?

❑ Yes	❑ No	Allergies
❑ Yes	❑ No	Low Blood or Anemia
❑ Yes	❑ No	Chest pain/tightness
❑ Yes	❑ No	Arthritis
❑ Yes	❑ No	Asthma
❑ Yes	❑ No	Prostate Trouble (men only)
❑ Yes	❑ No	Cancer
❑ Yes	❑ No	Stroke
❑ Yes	❑ No	Heart Disease
❑ Yes	❑ No	Diabetes or High Blood Sugar
❑ Yes	❑ No	Stomach or Gallbladder Problems
❑ Yes	❑ No	Jaundice or Hepatitis
❑ Yes	❑ No	High Cholesterol
❑ Yes	❑ No	High Blood Pressure
❑ Yes	❑ No	Heart Attack
❑ Yes	❑ No	Heartburn
❑ Yes	❑ No	Kidney or Bladder Trouble
❑ Yes	❑ No	Seizures or Convulsions
❑ Yes	❑ No	Thyroid Problem
❑ Yes	❑ No	Mental Illness
❑ Yes	❑ No	Heart Murmur

OTHER: _____

SURGERIES:

❑ Yes	❑ No	Angioplasty/Stents	Date: _____
❑ Yes	❑ No	Appendix	Date: _____
❑ Yes	❑ No	Back Surgery	Date: _____
❑ Yes	❑ No	Cardiac Bypass	Date: _____
❑ Yes	❑ No	Gallbladder	Date: _____
❑ Yes	❑ No	Hernia	Date: _____
❑ Yes	❑ No	Tonsillectomy	Date: _____
❑ Yes	❑ No	Vasectomy (male only)	Date: _____
❑ Yes	❑ No	Tubal Ligation (female only)	Date: _____
❑ Yes	❑ No	Hysterectomy (female only)	Date: _____

OTHER: _____

FOR WOMEN ONLY:
Age at onset of periods: _____ Date of last period: _____ Date of last mammogram: _____
Date of last Pap smear: _____
# of pregnancies: ____ # of births: _____ # of miscarriages/abortions: _____ Are you pregnant? ❑ Yes ❑ No

FAMILY HISTORY:
Is there a family history of any of the following? If yes, list who in your family.
❑ Yes ❑ No Alcohol Problems_____
❑ Yes ❑ No Heart Problems_____
❑ Yes ❑ No Cancer_____
❑ Yes ❑ No Diabetes_____
❑ Yes ❑ No High Blood Pressure_____
❑ Yes ❑ No Mental Illness_____
❑ Yes ❑ No Other_____

SOCIAL HISTORY:
Primary language spoken:_____
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Do you now or have you ever used tobacco? ❑ Yes ❑ No ❑ Former Type: _____
If yes, # packs per day:_____ # years smoked:_____ year quit:_____
Do you drink beverages with caffeine? ❑ Yes ❑ No If yes, how many per day? _____ Type: _____
Do you now or have you ever used alcohol? ❑ Yes ❑ No ❑ Former
Type: _____ How Often: _____ How Much: _____
Do you now or have you ever used drugs? (marijuana, cocaine, etc.) ❑ Yes ❑ No ❑ Former
Type: _____ How Often: _____

It is the patient's SOLE responsibility to obtain and deliver all prior medical records in order to properly evaluate and treat you, the patient. Any effort this office makes to obtain such records is merely a convenience to you but does not relieve you, the patient, of making sure we have your complete medical history.