Piedmont HealthCare

FOX INTERNAL MEDICINE

435 E. Statesville Ave.
Mooresville NC 28115
704.663.5056

Date:_____ Account _____

Welcome to Fox Internal Medicine. We are pleased to have you as our patient. If you are a new patient or have not seen us for 2 years, please complete the following health history prior to your appointment. Feel free to ask for assistance from the staff or your provider if you are unsure how to answer a question. We look forward to working with you to meet your healthcare needs!

## Personal Information

Name:_____ Marital Status: S M D W LS

What name would you like to be called?_____

Best number to reach you ___Home ___ Cell ___Work Number:_____

Pharmacy for your prescriptions:_____

## Personal Medical History

Are you currently being treated or have you been treated in the past for any of the following conditions:

| Condition | Currently Being Treated | Treated in the Past | Condition | Currently Being Treated | Treated in the Past |
|---|---|---|---|---|---|
| Heart Failure | | | Stomach Ulcer | | |
| Heart Attack | | | Depression | | |
| High Blood Pressure | | | Anxiety | | |
| Other Heart Disease | | | Emphysema (COPD) | | |
| High Cholesterol | | | Tuberculosis | | |
| Diabetes | | | Pneumonia | | |
| Stroke | | | HIV | | |
| Headaches | | | Thyroid Disease | | |
| Reflux/Indigestion | | | Cancer (specify type: _____) | | |

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|---|---|---|---|---|---|
| Asthma | | | Other | | |

## Past Surgical History

Please list any surgeries or hospitalizations with approximate dates:

| Surgery or Reason for Hospitalization | Date(s) |
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## Family Medical History

| | Gender | Age | Living –or- Deceased | General Health | Illness* | Cause of Death |
|---|---|---|---|---|---|---|
| Father | M | | | | | |
| Mother | F | | | | | |
| | | | | | | |
| Grandmothers | | | | | | |
| Maternal (Mother's side) | F | | | | | |
| Paternal (Father's side) | F | | | | | |
| | | | | | | |
| Grandfathers | | | | | | |
| Maternal (Mother's side) | M | | | | | |
| Paternal (Father's side) | M | | | | | |

*Please include cancer and type, diabetes, heart attacks, high blood pressure, stroke, tuberculosis, and other important illness.

## Social History

Do you, or have you ever smoked? YES NO If yes, at what age did you start?_____

If a former smoker, at what age did you stop?_____ How many pack did/do you smoke per day?_____

Have you or do you now dip or chew tobacco YES NO

Do you drink alcoholic beverages YES NO

If yes, how much and how often do you drink?_____ glasses/cans of beer/wine/hard liquor per day/week/month

Do you follow any special diet? YES NO If yes, please describe:_____

Do you get regular exercise? YES NO Describe type and frequency:_____

Do you see a dentist? YES NO Date of last visit:_____

Do you have any piercings or tattoos? If yes, please describe:_____

## Allergies

Please list any allergies or drug reactions

| Allergen (e.g. Peanuts, bee sting, etc.) | Reaction (e.g. Hives, eye swelling, wheezing) |
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## Medication History

Please list all prescriptions and Over-the-Counter medications you are currently taking or have taken in the past six months.

| Medication Name | Dosage (i.e. strength) | Instructions (i.e. how much you take and when) |
|---|---|---|
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## Immunizations and Preventive Health Screenings

Immunizations:

| Please enter approximate date of most recent administration of the immunizations listed | |
|---|---|
| Tetanus: | Pneumovax: |
| Hepatitis B series: | Prevnar: |
| Gardasil (females only): | Hepatitis A series: |
| Varicella (chickenpox): | Zostavax (shingles) |
| | |

Health Maintenance:

Please enter date of most recent screening completion

Colonoscopy :_____ Bone Density Test:_____

Pap Smear (female only):_____ Mammogram (female only):_____

Perform Monthly Breast self-examinations: YES NO

Prostate Exam (male only):_____ Thank you for taking the time to complete this form.