IF YOU HAVE NOT COMPLETED THIS PAPERWORK IN THE WAITING ROOM,PLEASE COMPLETE AND GIVE TO YOUR NURSE. THANK YOU

UT INTERNAL MEDICINE CENTER HISTORY & PHYSICAL FORM

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

Reason for your visit today? (Chief Complaint)_____

Place a check mark in the box if you are currently being treated for or have been treated for the following:

Y	N		Y	N		Y	N	
☐	☐	Anemia	☐	☐	Emphysema/COPD	☐	☐	Kidney Disease
☐	☐	Arrhythmia	☐	☐	Genetic Disorder	☐	☐	Kidney Stones
☐	☐	Arthritis	☐	☐	Gout	☐	☐	Osteoporosis
☐	☐	Asthma	☐	☐	Heart Attack	☐	☐	Peptic Ulcer Disease
☐	☐	Bleeding Disorder	☐	☐	Heart Disease	☐	☐	Prostate Disease
☐	☐	Bronchitis	☐	☐	Hepatitis	☐	☐	Rheumatoid Arthritis
☐	☐	Cancer	☐	☐	Hernia (groin)	☐	☐	Sexually Transmitted Disease
☐	☐	Depression	☐	☐	HIV	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	High Cholesterol	☐	☐	Thyroid Disorder
☐	☐	Diverticulitis	☐	☐	History of blood clots	☐	☐	Tuberculosis
☐	☐	Eczema	☐	☐	Hypertension	☐	☐	Other

Current Medications: List all the Medications you are currently taking including over-the-counter vitamins or supplements (If you need more room, please use the back of page)

Medication Name (Example: Lisinopril)	**Dose** (mg amount) (Example: 10mg)	**How often** (Example: Daily)

What pharmacy would you like us to use? Please list name, address and phone number.

_____

Allergies: Please list any allergies to medications and the reaction experienced (rash, throat swelling, etc.)

Medication you are allergic to:	**Reaction you have:**

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

Past Medical History: Please list any other medical conditions you have or have been treated for in the past.

Problem:	**Date:**

Surgical History: Please list any surgeries you have had and the date (or year) that it was performed.

Surgery	Date

Please list hospitalizations or ER visits within the last year:

Hospital/ER	**Reason**	**Date**

Please list any other doctors that you follow-up with and their specialty:

Doctor	**Specialty**

Social History:

Occupation:_____ Employer:_____

Education (highest level completed): _____ Marital Status: _____

Spouse's Name: _____ His/Her Employer:_____

Religious Preference (if any):_____

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

Y	N			
☐	☐	Current Smoker	How many packs per day?	
☐	☐	Former Smoker	How long did you smoke?	
			Age Started?	
			Age Quit?	
☐	☐	Dip/Chew		
☐	☐	E-Cigarettes (Vaping)		
☐	☐	Are you interested in quitting?		
☐	☐	Do you drink alcohol?	How many drinks per day?	
			Type of preferred drink?	
☐	☐	Have you ever used any recreational or IV drugs? (Example: marijuana, cocaine, heroin, etc.)	If yes, what type?	
☐	☐	Have you ever used any prescription medications that were not prescribed to you?	If yes, what type?	

Family History: Have any of the following occurred in a family member? If so, please indicate who (Ex: Mother, Sister)

Condition	Family Member	Condition	Family Member
Breast cancer		High Blood Pressure	
Colon cancer		Diabetes	
Ovarian cancer		Blood clots	
Uterine cancer		Birth defect	
Stroke or heart attack		Fibroids	
Endometriosis		Other:	

Females:

Last menstrual period_____ Length of period_____

Regular period _____ Irregular Period _____

Age at first period? _____ Age when you stopped having periods: _____

Last Pap smear_____ Have you ever had an abnormal Pap smear? _____

Do you do self-breast exams?_____ Date of Last Mammogram _____

Number of pregnancies _____ Miscarriages _____ Premature births_____

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

Review of System:

Have you had any of the following symptoms in the past four months? Check all that apply:

Y	N	**General**
☐	☐	Fever
☐	☐	Chills
☐	☐	Sweats
☐	☐	Fatigue
☐	☐	Weight loss
☐	☐	Other symptoms: _____
Y	**N**	**Eyes**
☐	☐	Vision loss -1 eye
☐	☐	Double vision
☐	☐	Vision loss – both eyes
☐	☐	Eye pain
☐	☐	Discharge
☐	☐	Other symptoms: _____
Y	**N**	**ENT**
☐	☐	Ringing in the ears
☐	☐	Earache
☐	☐	Decreased hearing
☐	☐	Nasal congestion
☐	☐	Nosebleeds
☐	☐	Difficulty swallowing
☐	☐	Sore throat
☐	☐	Other symptoms: _____
Y	**N**	**Cardiovascular**
☐	☐	Chest pain or discomfort
☐	☐	Racing/skipping heart beats
☐	☐	Shortness of breath with exertion
☐	☐	Palpitations
☐	☐	Swelling of hands or feet
☐	☐	Other symptoms: _____
Y	**N**	**Respiratory**
☐	☐	Cough
☐	☐	Coughing up blood
☐	☐	Chest discomfort
☐	☐	Wheezing
☐	☐	Other symptoms: _____
Y	**N**	**Gastrointestinal**
☐	☐	Excessive appetite
☐	☐	Loss of appetite
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Abdominal Pain
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Dark tarry stools
☐	☐	Other symptoms: _____
Y	**N**	**Genitourinary**
☐	☐	Urinary frequency
☐	☐	Painful urination
☐	☐	Genital Sores
☐	☐	Lack of sexual drive
☐	☐	Unusual urinary color
☐	☐	Other symptoms: _____
Y	**N**	**Musculoskeletal**
☐	☐	Joint pain
☐	☐	Back pain
☐	☐	Muscle weakness
☐	☐	Stiffness
☐	☐	Muscle aches
☐	☐	Other symptoms: _____
Y	**N**	**Dermatology**
☐	☐	Suspicious lesions
☐	☐	Dryness
☐	☐	Poor wound healing
☐	☐	Skin cancer
☐	☐	Other symptoms: _____
Y	**N**	**Neurological**
☐	☐	Poor balance
☐	☐	Headaches
☐	☐	Disturbances in coordination
☐	☐	Seizures
☐	☐	Tremors
☐	☐	Fainting
☐	☐	Other symptoms: _____
Y	**N**	**Psychological**
☐	☐	Anxiety
☐	☐	Thoughts of suicide
☐	☐	Depression
☐	☐	Thoughts of violence
☐	☐	Frightening visions/sounds
☐	☐	Other symptoms: _____
Y	**N**	**Endocrinology**
☐	☐	Excessive hunger
☐	☐	Cold intolerance
☐	☐	Heat intolerance
☐	☐	Excessive urination
☐	☐	Excessive thirst
☐	☐	Other symptoms: _____
Y	**N**	**Hematology**
☐	☐	Enlarged lymph nodes
☐	☐	Bleeding
☐	☐	Skin discoloration
☐	☐	Abnormal bruising
☐	☐	Other symptoms: _____
Y	**N**	**Allergy**
☐	☐	Persistent infections
☐	☐	Hives or rash
☐	☐	Seasonal allergies
☐	☐	Other symptoms: _____

Any other symptoms not listed above:_____

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

Vaccination History:

Have you had a:	**Yes**	**No**	**Year**
Pneumonia Vaccine?	◯	◯	
Hepatitis A vaccine? (series of 2)	◯	◯	
Hepatitis B vaccine? (series of 3)	◯	◯	
Chickenpox or vaccine?	◯	◯	
Shingles vaccine?	◯	◯	
HPV (Gardasil) vaccine?	◯	◯	
Covid-19 vaccine? Pfizer Moderna J&J (Select One)	Select One	Select Or	Dates?
If born after 1956, have you received a **second MMR** vaccine?	◯	◯	
Have you received a **tetanus** shot? When was your last **tetanus** shot?	◯	◯	
Do you get a yearly **flu** shot?	◯	◯	
Any exposure to TB? **TB** skin test results:	◯	◯	

Screening Questions:

Y	**N**	**Have you ever had**	**Date**
◯	◯	DEXA (Bone Scan for Osteoporosis)	
◯	◯	Mammogram	
◯	◯	Colonoscopy	
◯	◯	Pap Smear	

Advance Directives:

Do you have an advance directive (living will)?

◯ Yes – Please provide a copy for your file

◯ No – Our office can provide information about how to complete an Advance Directive

Have you assigned someone as your Power of Attorney for your health care?

◯ Yes – Name of Person:_____

◯ No – Our office can provide information regarding Power of Attorney for Health Care

Submit Form