INTERNAL MEDICINE PATIENT QUESTIONNAIRE

In preparation for your upcoming exam, please complete this form as thoroughly as possible and bring it with you to your appointment. ***Please continue on the back of the page if you require additional space.***

Name: ____ **Date of Birth:** __________________________

Medical History | Please list past illnesses, injuries, and operations:

Injury/Operation/Health Conditions	Date	Hospitalized?

Allergies | Please list allergies and type of reaction:

Allergy	Type of reaction? (e.g. rash, difficulty breathing, diarrhea, etc.)

Medications, Vitamins and Other Supplements | Please list all medications, vitamins, and other supplements that you currently take. Please indicate the dose and frequency for each:

Medication/Vitamin/ Supplement	Dose (mg)	Times per Day

Medication/Vitamin/ Supplement	Dose (mg)	Times per Day

How many servings of calcium do you get daily? _________ (e.g. milk, yogurt, cheese, etc.)
Are you on a special diet, and if so, why? ____

Providers and Suppliers | Please list other health care providers and suppliers (i.e. for diabetic supplies, oxygen, etc.):

Provider/Supplier Name	Specialty	What care do they provide?

Family History | Please check all that apply and provide details in "Notes" area below:

❑ Alcoholism	❑ Heart Attack	❑ Kidney Disease
❑ Cancers	❑ Heart Disease	❑ Mental Illness
❑ Depression	❑ High Cholesterol	❑ Stroke
❑ Diabetes	❑ High Blood Pressure	❑ Thyroid Disease
Notes:		

Advanced Care Planning:
I consent to discuss end-of-life planning with my healthcare provider at my upcoming appointment. **Yes / No**

______________________________________ ____________________ __________
Patient Signature Date RN/LPN Initials