Capital Internal Medicine

LOCATION OF OUR OFFICE: 3955 Patient Care Dr Lansing, MI 48911
PHONE: (517) 374-7600 FAX#: (855) 495-5457

PLEASE COMPLETE THIS QUESTIONNAIRE AND BRING WITH YOU TO YOUR SCHEDULED APPOINTMENT

Last name: First: Middle: Birthdate: _ / __ / ___.

PLEASE DESCRIBE ANY CURRENT/PRESENT PROBLEM(S):

PLEASE DESCRIBE ANY PRIOR MEDICAL PROBLEM(S) or DIAGNOSIS:

LIST YOUR PREVIOUS PRIMARY CARE DOCTOR and ANY SPECIALISTS THAT YOU SEE or HAVE SEEN IN THE PAST:

LIST ANY PRIOR HOSPITALIZATIONS and /or SURGERIES:

DATE	PROCEDURE	REASON

PLEASE LIST ANY ALLERGIES AND YOUR REACTION TO THEM

ALLERGY/MEDICATION	REACTION

PLEASE LIST MEDICATIONS YOU ARE USING:

MEDICATION TAKING	DOSAGE	REASON FOR USING

(May use back of page for any additional information)

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FEMALE MENSTRUAL HISTORY: Age at Onset? _____

Usual Flow: ❑ Light ❑ Moderate or ❑ Heavy ❑ Menopause

❑ Pain or Bleeding After Sex ❑ Pain or Cramps ❑ Flushing/Hot Spells

❑ Live Births ❑ Pregnancy ❑ Miscarriages ❑ Birth Control

Number of Children: _____ Number of Boys: _____ Number of Girls: _____

Family History: (Please check all boxes that apply in table below)

Please tell us about medical problems in your blood relatives. This can help us take better care of you. Fill out the chart below by checking all the appropriate boxes that apply to each relative.

	AGE (years old)	DECEASED (Y/N)	DIABETES	HYPERTENSION	HEART DISEASE/CHF/MI	STROKE	ASTHMA	CANCER	UNKNOWN	ALLERGIES	MENTAL ILLNESS	DEPRESSION	OSTEOPOROSIS	COPD	HYPERLIPIDEMIA
MOTHER		Y/N													
FATHER		Y/N													
MOTHERS MOTHER		Y/N													
MOTHERS FATHER		Y/N													
FATHERS MOTHER		Y/N													
FATHERS FATHER		Y/N													
BROTHERS		Y/N													
SISTERS		Y/N													
CHILDREN		Y/N													

Social History:

Marital Status: Single, Married, Divorced, Separated, Widowed

Occupation: _____ Retired: Yes, No

Education: _____ Level: Graduate Degree, Undergraduate degree,

Some College, High School only

Cigarette Use: Never Past use Packs/day _____
Current use Packs/day _____

Any Exposure to Second Hand Smoke: Yes No

Alcohol Use: Never used, past use, Beer, Wine, Liquor, Treatment for use

Caffeine Use: Never used, past use, Coffee, Tea, Cola's, ounces per day_____

Diet: No restrictions, Diabetic, Low Salt, Low fat/Low Cholesterol, Calorie Restriction, Fluid Restriction

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Exercise: Type: _____ Frequency_____ Length:_____

Illegal Drug Use: Never used, Past use, Type: _____ Treatment Yes No

Seat Belt Use: Yes No **Smoke Detectors**: Yes No

Victim of Domestic Violence: Yes No Current Past

Review of Systems:

(**Please circle all ROS that apply to you on the day of your visit, or in the recent past only**)

General Health: tiredness, fever, chills, night sweats, weight loss, weight gain,

Skin: rash, hives, itching, blisters, dry skin

Eyes: double vision, poor vision, blurred vision

Ear, Nose, Throat: sore throat, ringing in ears, sinus infections, bloody noses, voice changes Hearing loss, spinning, dizziness

Neck: thyroid masses, neck pain, stiffness

Lungs and Heart: shortness of breath, cough, coughing up blood, coughing up phlegm, wheezing, heart skipping, heart beating fast, pain in leg muscles when you walk, chest pressure, chest pain, chest tightness

Digestive System: vomiting, nausea, diarrhea, constipation, change in bowel habits, black stools, painful bowel movements, painful anal spasms, abdomen pain

Genitals and Urinary: frequent urination, slow urinary stream, burning or pain with urination, Unusual vaginal discharge, discharge from penis, change in sex drive

Muscles and Joints: pain, swelling, stiffness, decreased motion

Diabetic Symptoms: unusually thirsty, unusually large volume or frequent urination

Thyroid Symptoms: compared to others are you unusually cold or hot Yes No

Nervous System: weakness, numbness, imbalance, headaches, tremor (shaking)

Blood System: anemia, easy bruising, unusual bleeding when you cut yourself or brush your teeth

Infections: Measles, Mumps, German Measles, Chicken Pox, Shingles

Emotions: Depression, Anxiety

Additional Comments:

_____

_____

_____

Thank you for taking the time to fill out this form!