Riverside Medical, S.C.
Internal Medicine and Gastroenterology

MEDICAL HISTORY INFORMATION

NAME: _____ DOB: _____/_____/_____ DATE: _____

CHECK ALL THAT APPLY

☐ I am currently pregnant

☐ I am currently breastfeeding

CHILDHOOD ILLNESSES:

☐ Chicken Pox

VACCINATION STATUS

☐ Chicken Pox Year: _____
☐ Gardasil Year: _____
☐ Hepatitis A Year: _____
☐ Hepatitis B Year: _____
☐ Influenza (Flu) Year: _____
☐ Measles Year: _____
☐ Meningitis Year: _____
☐ Pneumonia Year: _____
☐ Shingles Year: _____
☐ Tetanus Year: _____

ALLERGIES

List any allergies:

_____
_____
_____
_____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No
If yes how many a day? _____
If no did you ever? ☐ Yes ☐ No
How long has it been since you quit? _____
Do you drink alcohol? ☐ Yes ☐ No
If yes, how much/how often? _____
Do you use drugs? ☐ Yes ☐ No
If yes, what do you use?
_____
Marital Status? _____
Occupation? _____

GENERAL HEALTH

☐ Allergies
☐ Anemia
☐ Addiction
☐ Anxiety
☐ Asthma
☐ Back Pain
☐ Bleeding Disorder
☐ Blood Clot (DVT or PE)
☐ Blood Transfusion
☐ Cancer Year diagnosed: _____
Type: _____
☐ Cataracts
☐ Crohn's Disease
☐ Colon Polyps
☐ Depression
Suicide attempt in past ☐ Yes ☐ No
☐ Diabetes ☐ Insulin
☐ Diverticulitis
☐ Diverticulosis
☐ Ear problems
☐ Emphysema/COPD
☐ Fibrocystic Breast Disease
☐ Fibromyalgia
☐ Gallstones
☐ Glaucoma
☐ Hay fever

☐ Hearing loss ☐ Hearing Aids
☐ Heart Attack Year: _____
Stents? _____
☐ Heart Disease
Type: _____
☐ Heart Murmur
☐ Hepatitis
☐ Hernia
☐ High blood pressure
☐ High Cholesterol
☐ High Triglycerides

☐ HIV/AIDS
☐ Insomnia
☐ Irritable Bowel Syndrome (IBS)
☐ Kidney problems
☐ Kidney Dialysis
☐ Kidney Stones
☐ Liver problems Type: _____
☐ Lupus
☐ Malaria
☐ MRSA
☐ Mental Illness
Type: _____
☐ Multiple Sclerosis
☐ Neck Pain
☐ Neuropathy
☐ Osteoarthritis
☐ Osteopenia
☐ Osteoporosis
☐ Pancreatitis
☐ Parkinson Disease
☐ Pneumonia
☐ Prostate problems
☐ Pulmonary Fibrosis
☐ Retinal Problems
☐ Rheumatoid Arthritis
☐ Rheumatological condition
Type: _____
☐ Seizures/Epilepsy
☐ Skin problem
☐ STDs Type: _____
☐ Stroke
☐ Thyroid Problem
☐ TIA
☐ Tuberculosis
☐ Tumor (not cancerous)
☐ Ulcerative Colitis
☐ Ulcers
☐ Vascular Disease
☐ Others:

PLEASE TURN OVER

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MEDICATIONS (List prescription or over the counter medications or supplements used):

Name of Medication	Frequency (daily, twice daily, etc)	Dose (mg, etc)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SURGERIES

Type	Year

PROCEDURES

Type	Year
☐ Angiogram (Cardiac Cath)	
☐ Biopsy of:	
☐ Colonoscopy	
☐ Cystoscopy	
☐ D&C	
☐ Endoscopy (EGD)	

FAMILY HISTORY

Member	Living	Deceased (age)	Heart Disease?	High Blood Pressure?	Diabetes?	Cancer?	Other?
Father							
Mother							
Sister							
Sister							
Brother							
Brother							
Children							
Children							
Maternal GF							
Maternal GM							
Paternal GF							
Paternal GM							
Other							