



Personal Health Summary

Internal Medicine Clinic

Name		
First	Middle/Maiden	Last
Today's Date		
Date of Birth		Medical Record #
Address		Telephone Number

The questions in this booklet have been written by the people who will care for you in the Internal Medicine Clinic. Please try to answer the questions carefully. It should take about 30 minutes. For most questions check the yes or no box. For some questions you will need to write information. If you have trouble reading or understanding the questions, ask someone to help you. If you prefer not to answer any of the questions, you are free to do so.

Answers to these questions will help your doctor understand your medical problems at the time of your first visit to the clinics. The booklet will then be put in your medical record at the University of North Carolina Hospitals, so it can be available whenever you visit the hospital. As with all your medical records, this booklet will be kept confidential.

Thank you for your help.

Before your appointment day:

If you have never been seen as a patient anywhere in UNC Hospitals, please call to pre-register between 8:00 AM and 7:30 PM Monday through Friday.

Long Distance Toll Free 1-800-634-8020

Local 966-2555

These numbers are for pre-registration ONLY – NOT FOR APPOINTMENTS!

Please bring on your appointment day:

1. Your insurance information
2. Your completed Personal Health Summary.
3. All medicines you are now taking
4. Copies of medical records and x-rays related to your present problems.

If you cannot keep your appointment, please cancel. Call as soon as you know you cannot, so that we can give your appointment slot to someone else who needs it. To cancel or reschedule your appointment, or if you have questions, please call 919-966-1459.

We appreciate your efforts to be on time for all appointments.

We are happy to welcome you to our Medicine Clinics and look forward to serving you.

General Information

What led you to schedule this appointment today?

What do you consider to be your main health problems?

1. _____

2. _____

Where do you usually get medical care?

Name of Doctor or Clinic _____

Address _____

Telephone Number _____

Did that doctor send you to our clinic? _____

Past Medical Problems

Yes

No

Are you taking any prescription medicines?

If so, list the name, dose and how often you are take them.

Name

Dose (mg)

pills per day

Do you take any over the counter medicines, vitamins or herbal remedies?

List them: _____

Have you ever had any bad effects from a medicine or injection?

If yes, describe _____

Have you ever been told you had any allergies (including latex or rubber)?

List them: _____

Have you had any surgery, operations, or serious injuries? List them:

Date _____ Surgery/operation _____

Have you ever been under a doctor's care or in a hospital for serious illnesses?

List them: _____

Do you follow a special diet? _____

Do you have a "living will" or health care power of attorney?

Who has your health care power of attorney? _____

Have you ever had a colonoscopy? Year _____

Have you ever received a blood transfusion? Year _____

Have you considered organ donation?

When was your last PAP smear? Date _____

Have you ever had an abnormal PAP Smear?

When was your last mammogram? Date _____

Have you ever had "shots" (immunizations) for:

YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	Polio	
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus	Date of most recent booster _____
<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal vaccine	Year _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	Year _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	Year _____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	Year _____
<input type="checkbox"/>	<input type="checkbox"/>	Zoster vaccine	Year _____
<input type="checkbox"/>	<input type="checkbox"/>	Other	Year _____

Social History

Where were you born? _____

How much schooling have you had?

1 2 3 4 5 6 7 8	9 10 11 12	1 2 3	1 2 3 4
Grade School	High School	Vocational School	College

What has been your main occupation? _____

What is your most recent job? _____

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Have you in the past or do you now smoke, use snuff or chew tobacco? If yes, how much and for how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever felt you ought to cut down on your drinking?
<input type="checkbox"/>	<input type="checkbox"/>	Have people annoyed you by criticizing your drinking?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever felt bad or guilty about your drinking?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a drink first thing in the morning?
<input type="checkbox"/>	<input type="checkbox"/>	Are you under any unusual strain at your job?
<input type="checkbox"/>	<input type="checkbox"/>	Are you employed? Are you (circle one): Single Married Divorced or Separated Widowed Who lives in your household? _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you sexually active? With man woman both
<input type="checkbox"/>	<input type="checkbox"/>	Are there any religious/spiritual or cultural practices which need to be included in your care (example: no blood/blood products)? If yes, describe: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any problems at home or with relatives? Explain: _____

In difficult times where, or to whom, do you turn to for support?

What do you do with your free time?

Yes **No**

- Do you need help walking? If yes, what do you use (circle all that apply):
Cane Walker Wheelchair Other _____
- Do you need help at home? What type? _____
- In the last year have you been hit, pushed shoved, kicked or threatened by a partner or someone close to you?
- Have you ever been hit, pushed, shoved, kicked or threatened by someone close to you?
- Are there guns in the house?
- Do you wear a seat belt?
- Do you exercise regularly?

Family History

Yes **No**

- Do any illnesses run in your family?
What are they? _____

Do any members of your family have:

- | | | | | |
|--------------------------|--------------------------|-----------------|-----------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | Who _____ | Age at onset _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | Who _____ | Age at onset _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast Cancer | Who _____ | Age at onset _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Colon Cancer | Who _____ | Age at onset _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Cancer | Who _____ | Age at onset _____ |

Others: _____

Review of Symptoms

Yes

No

Are you sick a lot of the time?

How would you describe your health? (Circle one)

Good

Fair

Poor

Do you tire easily?

Do you sleep poorly?

Have you lost weight in the past year without trying to lose?

If so, how much? _____

Have you lost your appetite lately?

Have you had any unexplained fevers?

Have you ever had any of the following?

Yes No

- Anemia (low blood)
- Asthma (wheezing)
- Diabetes (sugar)
- Heart trouble
- Hemorrhoids (piles)
- Hepatitis (yellow jaundice)
- High blood pressure
- Tuberculosis (TB)
- Kidney trouble
- Liver trouble
- Pneumonia
- Rheumatic fever
- Ulcers
- Sexually transmitted infection (syphilis, gonorrhea, chlamydia)
- Do you get shortness of breath that wakes you up from sleeping?
- Does your heart ever race or skip?
- Do you have swelling in your feet?
- So you sleep on two or more pillows?
- Do you get cramps in your legs while walking?
- Do you usually have a cough?
- Have you ever coughed or spit up blood?
- Are you short of breath when climbing stairs or up a hill?
- Have you had asthma (wheezing) attacks?
- Do you have trouble swallowing?
- Do you have stomach pains more than once a week?
- Are you troubled by vomiting or nausea?

Yes No

- Nervous breakdown
- Have you ever had any serious skin trouble?
- Do you have frequent sore throats?
- Is your hearing poor?
- Do you wear a hearing aid?
- Do you have constant ringing or noises in your ears?
- Are you having trouble with your vision?
- Do you have eye pain?
- Does your nose run or stop up a lot?
- Do you often have nosebleeds?
- Do you have sinus trouble?
- Are you missing many teeth?
- Do you wear plates or false teeth?
- Do sore or bleeding gums trouble you?
- Do you have pain or tightness in your chest when you are working or exercising?
- Are you troubled by diarrhea or constipation?
- Have your bowel habits changed recently?
- Have you ever had a bowel movement that was black, like tar, or bloody?
- Do you have trouble urinating (passing your water)?
- Does it burn when you urinate?
- Have you ever passed kidney stones?
- Do you urinate more than two times a night?
- Do you have trouble with incontinence (urine leaking)?
- Are your joints often painful or swollen?

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had jaundice (yellow eyes and skin)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a seizure, fit, spell or convulsion (epilepsy)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you get upset or irritated easily? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do frightening thoughts keep coming to your mind? |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you ever in a hospital for your nerves? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are there any sexual problems you want to discuss? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you lost interest in your usual activities? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been feeling down, depressed or hopeless? |

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any serious trouble with your back? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you suffer from severe headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever fainted (passed out)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you lose your balance and fall? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have weakness in any part of your body? |

Men Only

- | | | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had prostate trouble? |
|--------------------------|--------------------------|-------------------------------------|

Women Only

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take calcium? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking or have you taken hormone replacements? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had bleeding between periods or after the "change-of-life"? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have pain or lumps in your breasts? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have unusual vaginal discharge or itching? |

Reviewed by: _____