Dennis Jordanides, M.D.
Diplomate, American Board of Internal Medicine

Health History

Name_____

Date _____ Date of Birth _____

Active Medical Conditions

Do you have any current medical conditions?
☐No ☐Yes If yes. List below:

Surgical History (e.g. Appendectomy, Angioplasty, Hysterectomy, Tonsillectomy)

Procedure	**Date**

Do you take any medications? ☐No ☐Yes

If yes, Please list any medications that you are currently taking (include non-prescriptions)

Medication	**Dose**	**Frequency**

**Please list additional medications on back*

Vaccines

Type (e.g. TDAP, Flu, Shingles)	**Date**	**Vaccinator** (e.g. Rite-Aid, CVS)

Childhood History

Illness	**Year**
Chicken Pox	_____
Measles	_____
Mumps	_____
Polio	_____
Other _____	_____

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Allergies Any known drug allergies? ☐ No ☐ Yes

Please list all allergies including food, medication and environmental reaction.

Allergy	**Reaction** (e.g. Hives, Rash)	**Severity** (Mild, Mod., Severe)

Past Medical History: Have you ever been diagnosed with any of the following?

Illness/Condition	**Year**	**Illness/Condition**	**Year**
☐ Anxiety	_____	☐ Hyperthyroidism	_____
☐ Arthritis	_____	☐ Hypothyroidism	_____
☐ Asthma	_____	☐ Kidney Disease	_____
☐ Autoimmune Disorder	_____	☐ Kidney Stones	_____
☐ Bleeding Problems	_____	☐ Liver Disease	_____
☐ COPD	_____	☐ Mental Illness	_____
☐ Cancer: Type _____	_____	☐ Osteoporosis	_____
☐ Depression	_____	☐ Pulmonary Embolism	_____
☐ Diabetes	_____	☐ Reflex/GERD	_____
☐ Diverticulitis	_____	☐ Seizure	_____
☐ Gout	_____	☐ Stroke	_____
☐ Heart Disease	_____	☐ Tuberculosis	_____
☐ High Blood Pressure	_____	☐ Other _____	_____
☐ High Cholesterol	_____		

Social History

Occupation_____

What is your highest level of education? ☐ High School ☐ College ☐ Graduate School

Marital Status

☐ Single ☐ Married ☐ Partnered ☐ Co-habiting ☐ Separated ☐ Divorced ☐ Widowed

Sexual Orientation ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Exercise ☐ None ☐ Mild (<1 day per week)
☐ Moderate (1-3 days per week) ☐ Heavy (>3 days per week)

Tobacco History ☐ Never
☐ Former Quit Date_____ Years of use_____ Packs per day_____
☐ Current Years of use_____ Packs per day_____
Chewing Tobacco? ☐ No ☐ Yes Cans per day_____

Do you drink alcohol? ☐ No ☐ Yes Number of drinks per day___ Type (e.g. Wine, Beer)_____
Do you drink caffeine? ☐ No ☐ Yes Amount per day_____ Type (e.g. Coffee, Soda)_____
History of recreational drug use ☐ No ☐ Yes Type of drug _____

Advanced Directive? ☐ No ☐ Yes (Please provide copy to provider)

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Family History

Do you have any family history of serious illness? ☐No ☐Yes If yes, list below:

Family Member	Deceased?	Current age or age at death	Heart Disease	High Blood Pressure	High Cholesterol	Diabetes	Stroke	Seizures	Autoimmune Disorders	Bleeding Problems	Cancer	Mental Illness	Other (please list)
Father													
Mother													
Sibling													
Sibling													
Maternal Grandmother													
Maternal Grandfather													
Paternal Grandmother													
Paternal Grandfather													
Child													
Child													
Other													

Current Specialists

1) Name _____ 2) Name _____

Specialty _____ Specialty _____

Phone _____ Phone _____

Preferred Pharmacy

Name _____ Address _____

Gynecological History

Last Menstrual Period _____

How many pregnancies have you had? _____

How many children do you have? _____

Have you ever had an abnormal pap smear? _____

Have you ever had a hysterectomy? _____

Have your ovaries been removed? _____

Health Maintenance

Exam	Date	Exam	Date
Labs		Prostate	
Cholesterol Screening		PAP	
Cardiac Stress Test		Mammogram	
Colonoscopy		DEXA	

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