The Internal Medicine Group
Affiliated with Lawrence Memorial Hospital

Patient Health Assessment

Date _____ Name _____Date of Birth_____

DRUG ALLERGIES: *include any over-the –counter, herbals, or vitamins*_____

_____

Other Allergies: *for example-foods*_____

CURRENT MEDICATIONS: *including over-the-counter, herbal and vitamins*

Medication	Dose	Frequency
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

Are there any of your current medications that you do not understand or have questions about? □Yes □ No
If Yes, explain in your words_____

Are there any problems or reasons to *NOT* taking your medications as prescribed? □ Yes □ No
If Yes, explain in your words_____

MEDICAL HISTORY

Please check if you currently have or have had any of the following:

□ Anxiety
□ Asthma
□ COPD/Emphysema
□ Dementia/Alzheimer's Disease
□ Diabetes
□ Depression/Other mental
□ Cancer: _____
□ Heart disease
□ High blood pressure
□ High cholesterol

Other medical problems not listed: _____
_____

SURGICAL PROCEDURES:

1)_____
2)_____
3)_____
4)_____
5)_____

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VACCINATIONS: *Please list any vaccinations you have received here or at another location*

□ Tetanus/Diphtheria TD Date: _____
□ TDAP (diphtheria added to TD) Date: _____
□ Shingles Date: _____
□ HPV (series of 3) Date:_____
□ Hepatitis A (series of 2) Date: _____
□ Hepatitis B (series of 3) Date: _____
□ Meningitis Date: _____
□ Chicken pox (varicella) Date: _____
□Had the disease Date: _____
□ Influenza/"FLU" Date: _____

□ Pneumonia (which one if known/date)_____Pneumovax 23_____Prevnar 13_____

Last Colonoscopy and where completed_____

Female Only:

Date last period began _____ If you do not have periods, when did they stop? _____
When was your last Pap? _____Have you ever had an abnormal Pap? □Yes □ No
Treatment/year for abnormal Pap: _____
Number of times pregnant _____Births _____
Ages of Children _____ Are you considering pregnancy in the next year? □ Yes □ No
Last mammogram? □ Yes □ No If yes, when/where? _____
Last bone density exam_____

Male Only:

□ Concerns about erectile dysfunction
□ Changes in urination
□ Last PSA
□ Other: _____

FAMILY MEDICAL HISTORY

List health issues of the following family member, such as cancer, heart disease, high blood pressure, mental illness, allergies, arthritis, diabetes, dementia or any other health concerns

Mother: _____ **Maternal Grandmother:** _____
Father: _____ **Paternal Grandmother:** _____
Sibling: _____ **Maternal Grandfather:** _____
Sibling: _____ **Paternal Grandfather:** _____

Why do we ask for goals? It helps us to understand what **YOU** want to work on to improve the quality of your life.

List or name at least 1 thing that you want to work on to improve the quality of your life or that you would like to achieve. (example-walk more, less pain, be able to buy my meds, understand my meds, reach a fitness goal)

_____

_____

List the names of any other health care providers/specialists you are currently seeing:

_____
_____
_____