Wake Internal Medicine Consultants, Inc.
THE TRIANGLE'S PREMIER MULTI-SPECIALTY CLINIC

Medical History Form

Patient Information		
First Name	Last Name	Date of Birth
Primary Physician	Chart #	
Reason for Visit (Chief Complaint)		

Family History	Please check the box if your family has a history of:					
	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Medical History — Please check the boxes that apply to you

- ☐ Headache
- ☐ Shortness of Breath
- ☐ Heart Palpitations
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Dizziness/Fainting
- ☐ Peripheral Vascular Disease
- ☐ Allergies/Hay Fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Ulcer
- ☐ GI Disorder
- ☐ Lactose Intolerant
- ☐ Gallbladder Disease
- ☐ Prostate Disease
- ☐ Bowel Irregularity
- ☐ Incontinence
- ☐ Venereal Disease
- ☐ Frequent Infections
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Nervousness
- ☐ Depression
- ☐ Gout
- ☐ Scarlet Fever
- ☐ Chronic Rashes
- ☐ Rheumatic Fever
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Polio
- ☐ Diphtheria
- ☐ Tetanus
- ☐ Sexual/Menstrual Dysfunction
- ☐ Other _____
- ☐ Other _____

Hospitalization or Surgery:	
Reason	Date
1.	
2.	
3.	
4.	

Allergies	
1.	5.
2.	6.
3.	7.
4.	8.

Current Medication(s):				
Medication Name	Reason for Medication	Dosage	Frequency	Date Started
1.				
2.				
3.				
4.				
5.				

Personal Habits:	
☐ Yes ☐ No	Do you smoke or have you ever smoked? If yes, how much per day and for how long?
☐ Yes ☐ No	Do you exercise? If yes, how often?
☐ Yes ☐ No	Do you drink caffeine? How much per day?
☐ Yes ☐ No	Do you drink alcohol? Type: Amount:
☐ Yes ☐ No	Do you diet? Salt intake: Fat intake:
☐ Yes ☐ No	Do you come in contact with blood/bodily fluid at work?

Sleep Habits:	
☐ Yes ☐ No	Do you have difficulty falling asleep?
☐ Yes ☐ No	Do you have continuity disturbances?
☐ Yes ☐ No	Do you snore?
☐ Yes ☐ No	Do you awaken early in the morning?
☐ Yes ☐ No	Do you have daytime drowsiness
☐ Yes ☐ No	Other:

Patient Signature: _____ Date: _____