

Thunderbird Internal Medicine

5620 W. Thunderbird Suite F-1

Name _____

Date _____ Chart# _____ Age _____

Past Medical History

<input type="checkbox"/> Heart Attack/Disease	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Deep Venous Thrombosis (DVT)	<input type="checkbox"/> Kidney Stones/Problems	<input type="checkbox"/> Gout	
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Valley Fever	For Office Use Only
<input type="checkbox"/> Tuberculosis/(+)Skin test	<input type="checkbox"/> Asthma/Emphysema	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Degenerative Arthritis	<input type="checkbox"/> Allergies	HT _____
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Peptic Ulcer	Wt _____
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hepatitis/Liver Problem	<input type="checkbox"/> Diabetes	BP _____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Stroke	HR _____
<input type="checkbox"/> Menopause/ERT ()	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Osteoporosis	Temp _____
	<input type="checkbox"/> Migraine	<input type="checkbox"/> Other _____	Plan _____

Past Surgical History

<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Gallbladder	
<input type="checkbox"/> Knee/Shoulder/Hip Surgery	<input type="checkbox"/> Thyroid Surgery	<input type="checkbox"/> Hysterectomy/BSO	
<input type="checkbox"/> Breast Surgery/biopsy	<input type="checkbox"/> Prostate Surgery	<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Heart Bypass	<input type="checkbox"/> Cataract R () L ()	<input type="checkbox"/> Hernia	
<input type="checkbox"/> Back Surgery	<input type="checkbox"/> C-section	<input type="checkbox"/> Other _____	
	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	

Medications

Name	Dose	Frequency	Name	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies (reaction)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations

<input type="checkbox"/> Tetanus (19__)	<input type="checkbox"/> Influenza (within last year)	<input type="checkbox"/> Hepatitis B (19__)
<input type="checkbox"/> Pneumovax(19__)	<input type="checkbox"/> Chicken Pox Vaccine	<input type="checkbox"/> Other _____

Social History

Occupation _____ Marital Status: Single () Married () Widowed () Divorced ()

Tobacco Now () Never () In the Past () Amount per day _____ Year quit _____ Age Started _____

Alcohol Never () Rare () Occasional () Moderate () Heavy () Amount/type per day _____

Family History

	Major Medical Problems	Age of Death	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers #__	_____	_____	_____
Sisters #__	_____	_____	_____
Children #__	_____	_____	_____

Family History of: Breast Cancer (); Colon Cancer (); Diabetes (); High Blood Pressure (); Early Heart attack ()

Preventative Medicine

Last Pap (month/year) _____/_____/_____ Last Mammogram _____/_____/_____ Last Protoscopic Exam _____/_____/_____