Bishnu P. Verma, M.D., P.A.

Internal Medicine **Diplomate ABIM in Internal Medicine**

American College of Physicians
Internal Medicine/Doctors for Adults

HEALTH HISTORY (Confidential)

Name: ____ Today's Date: ________/ _______/ _______

Age: ________ Birthdate: ____________________ What is the Reason for this Visit ____

Allergies to Medicines or Substances ____

MEDICATIONS: (List medications that you are currently taking)

CONDITIONS Check (✓) conditions you have, or have had in the past.

☐ Alcoholism	☐ Anemia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump
☐ Cancer	☐ Cataracts	☐ Diabetes	☐ Emphysema	☐ Epilepsy	☐ Gout
☐ Heart Disease	☐ Hepatitis	☐ High Cholesterol	☐ High Blood Pressure	☐ Kidney Disease	☐ Live Disease
☐ Migraine Headaches	☐ Pacemaker	☐ Pneumonia	☐ Prostate Problem	☐ Psychiatric Care	☐ Stroke
☐ Suicide Attempt	☐ Thyroid Problems	☐ Ulcers	☐ Vaginal Infections	☐ Venereal Disease	☐ Other ______________

DATE OF:
Last Menstrual Period_______________________ Last Pap Smear_______________________ Last Mammogram_____________________

FAMILY HISTORY: Fill in Health information about Your Family. Check (✓) if Your Blood Relatives had any of the following:

Disease	Relationship to You
Cancer	
Diabetes	
Heart Disease, Stroke	
High Blood Pressure	

HOSPITALIZATIONS / SURGICAL HISTORY

Year	Reason for Hospitalization

IMMUNIZATIONS

☐ Influenza Vaccine Date_________________________________ ☐ Pneumonia Vaccine Date____________________________________

☐ Tetanus Booster Date__________________________________

Have you ever had a Blood Transfusion?	☐ Yes	☐ No
Do you have an Advance Directive (Living Will) for your Medical Care?	☐ Yes	☐ No

I certify that the above information is correct to the best of my knowledge.

____ _____________________________________

Signature Date

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