



**AVERLY INTERNAL MEDICINE, LLC**  
**NOEL B. F. FEINBERG, MD.**  
DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE

## Medical History

Date \_\_\_\_\_

Name _____	Age _____ Birthdate _____
Address _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
_____	Home Phone _____
Occupation _____	Work Phone _____
_____	Emergency Contact _____
_____	Phone _____
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
If married, spouse's name _____	
Children's names and ages _____	

**Allergies to Medications, X-Ray Dyes, or Other Substances**       No     Yes  
 (If yes, please list name of medicine and type of reaction)

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Past Medical History and Review of Systems**  
 Please check off if you have had any problems with or are presently experiencing any of the following:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Unexplained weight gain/loss	<input type="checkbox"/> Low back problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Skin diseases
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> T.B.	<input type="checkbox"/> Gall Bladder disease	<input type="checkbox"/> Blood disorders
<input type="checkbox"/> Chest pain/chest tightness	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Colitis	<input type="checkbox"/> Venereal diseases
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Abdominal discomfort	<input type="checkbox"/> Hepatitis or jaundice	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Nausea	<input type="checkbox"/> Head or neck radiation	<input type="checkbox"/> Anemia
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Headache	<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Constipation	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Gout
<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Impotence or Erectile Dysfunction
<input checked="" type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Ulcers		<input type="checkbox"/> Other _____

**Gynecologic and Obstetric History**

Age at onset of periods \_\_\_\_\_    Frequency \_\_\_\_\_    Length of Periods \_\_\_\_\_  
 Pregnancies \_\_\_\_\_    Births \_\_\_\_\_    Miscarriages \_\_\_\_\_

Prolonged or abnormal bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please describe) _____
Leakage of urine	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please describe) _____
Pelvic Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please describe) _____
Abnormal discharge	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please describe) _____
History of abnormal Pap smear	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please describe) _____

This information is for use by your physician as part of your confidential medical record.

Please continue on the next page

# Medical History

Name \_\_\_\_\_

Date \_\_\_\_\_

**Please List and Supply the Dates of:**

Operations \_\_\_\_\_

Hospitalizations other than for surgery \_\_\_\_\_

Immunization history-have you had:

Hepatitis B? <input type="checkbox"/> No <input type="checkbox"/> Yes When? _____	Pneumovax immunization? <input type="checkbox"/> No <input type="checkbox"/> Yes When? _____
Other? <input type="checkbox"/> No <input type="checkbox"/> Yes When? _____	Flu immunization? <input type="checkbox"/> No <input type="checkbox"/> Yes When? _____
	Tetanus immunization? <input type="checkbox"/> No <input type="checkbox"/> Yes When? _____

When was your last:

Pap Smear? _____	Breast Exam? _____	Stool check for blood? _____
Mammogram? _____	Cholesterol check? _____	Prostate exam? _____

**Family History** Has any member of your family (including parents, grandparents, and siblings) ever had the following?

illness	Which family members?	Age when diagnosed
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression, etc.)	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____
Other _____	_____	_____

**Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)**

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Prevention**

Do you wear seat belts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, why not? _____
Do you wear a bike helmet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type, duration and number of times per week? _____
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much per week? _____
Do you drink coffee?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many cups per day? _____
Do you drink tea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many cups per day? _____
If there is a gun in your home, do you keep it unloaded and out of children's reach?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain: _____
Do you wish to be tested for AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain: _____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you ever feel afraid of your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you have a "living will"?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a donor card?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Method of birth control?		

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