Internal Medicine
of West Michigan

NEW Patient History

IMWM

Full Name: ________________________ Birth Date: __________ Today's Date: __________
Gender and Identity: ____________________ Personal Pronouns: ____________________
Email Address: ____
How did you hear about our office? ____________________________________

PERSONAL MEDICAL HISTORY

DISEASE / CONDITION	CURRENT	PAST	COMMENTS
Alcoholism			
Asthma			
Cancer (*type:* __________)			
COPD			
Depression /Anxiety/Insomnia			
Diabetes (*type:* __________)			
Heart Disease			
High Blood Pressure (*Hypertension*)			
High Cholesterol			
Kidney (*Renal*) Disease			
Migraines/Headaches			
Stroke			
Other:			
Other:			

MEDICATIONS

NAME, DOSE & FREQUENCY	

ALLERGIES

SURGERY / HOSPITALIZATIONS HISTORY

TYPE (*Specify Left / Right*)	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of last period:	Age of First Period:
Total Number of Pregnancies:	Age of Menopause:
Number of Living Children:	
Pregnancy Complications:	
Date of Last Pap Smear:	History of Abnormal Pap? Yes / No
Date of Last Mammogram:	History of Abnormal Mammogram? Yes / No

ADDITIONAL HEALTH HISTORY *(include date)*

Vasectomy:
Colonoscopy:
Bone Density:

SOCIAL HISTORY

Occupation:	Drink Alcohol? YES / NO How much? (Drinks/day):
Marital Status (*circle one)*: Single, Married, Divorced, Separated, Partner, Spouse	Use Tobacco/Nicotine? YES / NO How much? (Packs/day):
Recreational or Illicit Drugs? YES / NO	Drink Pop/Caffeinated beverages? YES / NO
Do you Exercise? YES / NO – What Activities?	

FAMILY MEDICAL HISTORY

DISEASE / CONDITION	**FAMILY MEMBER / AGE / AGE AT DEATH**
Alcoholism	
Asthma	
Cancer (*type:*___________________)	
COPD	
Depression /Anxiety/Insomnia	
Diabetes (*type:*_________________)	
Heart Disease	
High Blood Pressure (*Hypertension*)	
High Cholesterol	
Kidney (*Renal*) Disease	
Migraines/Headaches	
Stroke	
Other:	
Other:	

IMMUNIZATIONS (*include date)*

Tetanus:	Pneumonia:	Shingrix:	COVID-19:

Do you have a Living Will and/or Durable Power of Attorney for your Health Care? YES / NO

Patient Name (*please print)*:____

Patient Signature: ____**Today's Date:** _________________

Physician Signature: ____Today's Date: ___________________