



BRUNSWICK INTERNAL MEDICINE GROUP, PC INTERJIT SINGH KAINTH MD

HEALTH HISTORY

Name:	Gender:	M F Date of I	Birth:	
Date of last physical exami	nation:	Reason for this visit:		
Pharmacy:		Telephone: ()		
SYMPTOMS				
General General Chills Depression Dizziness Fainting Fever Forgetfulness Headache Loss of Sleep Loss of Sleep Loss of Weight Nervousness Numbness Sweats Muscle/Joint/Bone Pain, Weakness, Numbness: Arms Back Legs Feet Neck Hands Shoulders Genito-Urinary Blood in Urine Frequent Urination Frequent Urination	Gastrointestinal Appetite Poor Bloating Bowel Changes Constipation Diarrhea Excessive Hunger Excessive thirst Gas Hemorrhoids Indigestion Nausea Rectal Bleeding Stomach Pain Vomiting Vomiting Blood Cardiovascular Chest Pain High Blood Pressure Irregular Heart Beat Low Blood Pressure Poor Circulation Rapid Heart Beat	Eye, Ear, Nose, Throat Bleeding Gums Blurred Vision Crossed Eyes Difficulty Swallowing Double Vision Earache Ear Discharge Hay Fever Hoarseness Loss of Hearing Nosebleeds Persistent Cough Ringing in Ears Sinus Problems Vision – Flashes Vision – Flashes Vision – Halos Skin Bruise Easily Hives Itching Change in Moles Rash	MEN only Breast Lump Erection Difficulties Lump in Testicles Penis Discharge Sore on Penis Other WOMEN only Abnormal Pap Smear Bleeding Between Periods Breast Lump Extreme Menstrual Pain Hot Flashes Nipple Discharge Painful Intercourse Vaginal Discharge Other LMP Date Date of last Pap Smear Have You Had A Mammogram? Are You Pregnant? Number of Children	
Lack of Bladder Control Painful Urination	Swelling of Ankles Varicose Veins	Scars Sore that won't heal		

CONDITIONS

Aids	Chemical Dependency	High Cholesterol	Prostate Problem
Alcoholism	Chicken Pox	HTV Positive	Psychiatric Care
Anemia	Diabetes	Kidney Disease	Rheumatic Fever
Anorexia	Emphysema	Liver Disease	Scarlet Fever
Appendicitis	Epilepsy	Measles	Stroke
Arthritis	Glaucoma	Migraine Headaches	Suicide Attempt
Asthma	Goiter	Miscarriage	Thyroid Problems
Bleeding Disorders	Gonorrhea	Mononucleosis	Tonsillitis
Breast Lump	Gout	Multiple Sclerosis	Tuberculosis
Bronchitis	Heart Disease	Mumps	Typhoid Fever
Bulimia	Hepatitis	Pacemaker	Ulcers
Cancer	Hernia	Pneumonia	Vaginal Infections
Cataracts	Herpes	Polio	Venereal Disease

ALLERGIES TO MEDICATIONS or Substances ____

		State of	If deceased,	If deceased,	Indicate if your blood relatives had any of the following:		
Relation	Age	Health	age at death	cause of death?		Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

FAMILY HISTORY Fill in health information about your family

HOSPITALIZATION/Serious Illness/Injuries			PREGNANCY HISTORY		
Year	Hospital	Reason and Outcome	Year of Birth	Gender of Child	Complications if any

Have you ever had a blood transfusion? Yes No If yes, please give approximate dates:			HEALTH HABITS Indicate which substances you use and quantity		
List of Medications	Mg	Quantity	Substance	Quantity	
			Caffeine		
			Tobacco		
			Drugs		
			Alcohol		
			Occupational Concerns Indicate if your work exposes you to:		
			Stress		
			Hazardous Substances		
			Heavy Lifting		
			Other		

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.