PIEDMONT INTERNAL MEDICINE, PULMONARY AND INFECTIOUS DISEASES, P.A.

Name: _____ Date: _____

Please indicate any past or present illnesses you or your family members have:

	YOU	FAMILY
ALCOHOLISM		
EPILEPSY/SEIZURES		
THYROID		
TUBERCULOSIS		
HIV/AIDS		
GLAUCOMA		
STROKE		
ANEMIA		
GOUT		
DIABETES		
CHOLESTEROL		
HEART TROUBLE		
RHEUMATISM/ ARTHRITIS		
CANCER/TUMOR		
HIGH BLOOD PRESSURE		
ANXIETY		
ASTHMA/COPD		
LIVER DISEASE		
KIDNEY DISEASE		

SOCIAL HISTORY:		
	YES NO	
Smoking:		If yes: How many packs per day?
		How many years have you been smoking?
Alcohol:		How much and how often do you drink in week?
Illegal Drug Use:		
Exercise:		Frequency:

PREVIOUS SURGERIES:

_____

_____

_____

_____

CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

_____

DRUG ALLERGIES: _____

RECENT HOSPITALIZATION	WHERE	WHEN	REASON