





LITTLETON INTERNAL MEDICINE  
ASSOCIATES

Specialists in Prevention Diagnosis and Treatment of Adult Illness

Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Surgical History:**

Type of Surgery and Reason: \_\_\_\_\_ Year: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History:** (active or inactive) Check those that are applicable

- |   |   |
|---|---|
| <input type="checkbox"/> CVA (stroke)                 | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> TIA (mini stroke)            | <input type="checkbox"/> Diabetes                   |
| <input type="checkbox"/> Seizure                      | <input type="checkbox"/> Obesity                    |
| <input type="checkbox"/> Parkinson's                  | <input type="checkbox"/> Osteoporosis               |
| <input type="checkbox"/> Alzheimer's                  | <input type="checkbox"/> Osteoarthritis             |
| <input type="checkbox"/> Memory Loss                  | <input type="checkbox"/> Rheumatoid Arthritis       |
| <input type="checkbox"/> Headache/Migraine            | <input type="checkbox"/> Fibromyalgia               |
| <input type="checkbox"/> Angina (chest pain)          | <input type="checkbox"/> Gout                       |
| <input type="checkbox"/> Congestive Heart Failure     | <input type="checkbox"/> Lupus                      |
| <input type="checkbox"/> Heart Value Disease          | <input type="checkbox"/> Anxiety                    |
| <input type="checkbox"/> Abnormal Heart Rhythm        | <input type="checkbox"/> Depression                 |
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Bipolar Disorder           |
| <input type="checkbox"/> High Cholesterol             | <input type="checkbox"/> Alcoholism/Substance Abuse |
| <input type="checkbox"/> Blood Clots/DVT              | <input type="checkbox"/> Psychiatrist/Psychologist  |
| <input type="checkbox"/> Coronary Artery Disease      | <input type="checkbox"/> Irregular Periods          |
| <input type="checkbox"/> Coronary Artery Stent/Bypass | <input type="checkbox"/> Menopause/Age              |
| <input type="checkbox"/> Stomach Ulcers               | <input type="checkbox"/> Glaucoma                   |
| <input type="checkbox"/> Irritable Bowel Syndrome     | <input type="checkbox"/> Cataracts                  |
| <input type="checkbox"/> GERD, Reflux                 | <input type="checkbox"/> HIV/AIDS                   |
| <input type="checkbox"/> Gallstones                   |   |
| <input type="checkbox"/> Diverticulitis               | Comments/Other:                                     |
| <input type="checkbox"/> Liver Disease/Hepatitis      | _____   |
| <input type="checkbox"/> Pancreatitis                 | _____   |
| <input type="checkbox"/> Colon Polyps                 | _____   |
| <input type="checkbox"/> Asthma/Bronchitis            | _____   |
| <input type="checkbox"/> COPD/Emphysema               | _____   |
| <input type="checkbox"/> Emphysema                    | _____   |
| <input type="checkbox"/> Tuberculosis                 | _____   |
| <input type="checkbox"/> Sleep Apnea                  |   |
| <input type="checkbox"/> Kidney Disease               |   |
| <input type="checkbox"/> Kidney Stones                |   |
| <input type="checkbox"/> Reoccurring UTI's            |   |
| <input type="checkbox"/> Bleeding Disorder            |   |
| <input type="checkbox"/> Cancer (Type): _____         |   |



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Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

Social History:

- Married
- Single
- Widowed
- Divorced

Do you exercise: Yes No  
If so, how often/type? \_\_\_\_\_

Children:  Yes  No  
Sons: # \_\_\_\_\_ Age(s): \_\_\_\_\_  
Daughters: # \_\_\_\_\_ Age(s): \_\_\_\_\_

Do you drink alcohol? Yes No  
If so, how many drinks per week?

Occupation: \_\_\_\_\_

Do you use tobacco?  
How many cigarettes/pks per day?  
Have you ever smoked? Yes No  
How long:

Education: \_\_\_\_\_

When did you quit?

Advanced Directives:

Do you currently use recreational drugs?  
\_\_\_\_\_

Living Will:  Yes  No  
Power Attorney:  Yes  No

Family Health History:

Father:  Living  Deceased | Age: \_\_\_\_\_ Medical Problems: \_\_\_\_\_  
Mother:  Living  Deceased | Age: \_\_\_\_\_ Medical Problems: \_\_\_\_\_  
Brother(s):  Living  Deceased | Age(s): \_\_\_\_\_ Medical Problems: \_\_\_\_\_  
Sister(s):  Living  Deceased | Age(s): \_\_\_\_\_ Medical Problems: \_\_\_\_\_

Health Maintenance:

Tetanus Vaccine: _____	Date: _____	Eye Exam: _____	Date: _____
Pneumonia Vaccine: _____		Mammogram: _____	
Shingles Vaccine: _____		Bone Density: _____	
Influenza Vaccine: _____		Pap smear: _____	
Prostate Exam: _____		Skin Check: _____	
Dental Exam: _____		Colonoscopy: _____	
Cardiac Stress Test: _____		Carotid Ultrasound: _____	
Abdominal Aortic Aneurysm (AAA) Screen: _____			

Other Providers You See  
Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
  
Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
  
Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Specialty  
\_\_\_\_\_  
  
\_\_\_\_\_  
  
\_\_\_\_\_