KEVIN L. JACKSON, M.D.
INTERNAL MEDICINE

Patient Personal History

Patient Name: _____ **Date**: _____

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

PresentMedicalComplaints/Symptoms:_____
_____
_____
_____

Drug Allergies and Reactions:_____
_____
_____

Please provide a list of your current medications and attach to this document?

Preferred Pharmacy Name and Location: _____

Physicians currently treating you: _____
_____

Family History:	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Epilepsy/Convulsions	_____	_____	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____

Hospitalization or Surgery

Reason	Date	Reason	Date

Past Medical History

Headache	Claudication	Liver disease	Incontinence
Hypertension	MI	Ulcer	Venereal disease
Stroke/TIA	Congenital heart disease	GI disorder	Anemia
Epilepsy	Orthopnea	Lactose intolerance	Gout
Fatigue	Hyperlipidemia	Renal disease	Scarlet fever
Shortness of breath	Congestive heart failure	GU disorder	Rheumatic fever
Heart palpitations	Arrhythmia	Sexual dysfunction	Diabetes
Heart murmur	Allergies/Hay fever	Menstrual dysfunction	Endocrine disease
Chest pain/Angina	Asthma	Bowel Irregularity	Arthritis
Dizziness/Fainting	COPD	Prostate disease	Osteoporosis
Anxiety			

Routine Health Screening

Colonoscopy: _____ **PSA:** _____
Mammogram: _____ **Pap Smear:** _____
Eye Exam: _____ **Flu/Pneumonia Vaccine:** _____

Habits

Tobacco Use Packs daily: _____ How many years? _____ Date stopped: _____
Smokeless: _____ How many years? _____ Date stopped: _____
Caffeine How much consumed daily? _____
Alcohol How much consumed daily? _____
Exercise Routine and frequency? _____
Sleep Routine? _____

Do you have any metal in your body? **Yes** **No**
If so, where? _____

Do you need any assistance with and of the following?

Taking medications	**Meal preparation**	**Bathing/Toileting**	**Shopping**
Finances	**Housework**	**Bladder Control Issues**	**Transportation Issues**

Have you recently experienced any of the following?

Little interest or pleasure in doing things?	**Yes**	**No**
Feeling down, depressed or hopeless?	**Yes**	**No**
Loss of energy?	**Yes**	**No**
Difficulty sleeping?	**Yes**	**No**
Difficulty getting motivated or enjoying yourself?	**Yes**	**No**
Difficulty controlling thought?	**Yes**	**No**
Feeling blue?	**Yes**	**No**
Hoarseness?	**Yes**	**No**
Thoughts of suicide or hurting yourself or others?	**Yes**	**No**
Loss of memory?	**Yes**	**No**
Dislike of being around others?	**Yes**	**No**
Recent falls?	**Yes**	**No**

Neurologic:

Do you frequently have severe headaches?	**Yes**	**No**
Do they throb or pulsate?	**Yes**	**No**
Do they cause visual disturbance?	**Yes**	**No**
Do they occur on one side of the head?	**Yes**	**No**
Have you ever fainted?	**Yes**	**No**
Have you ever had a seizure?	**Yes**	**No**
Have you ever had double vision?	**Yes**	**No**
Spells of weakness of an arm or leg?	**Yes**	**No**
Dizziness?	**Yes**	**No**
Ringing in ears?	**Yes**	**No**

G.U.
Have you experienced recent:

Burning when urinating?	**Yes**	**No**
Blood in urine?	**Yes**	**No**
Trouble starting to urinate?	**Yes**	**No**
Getting up frequently at night to urinate?	**Yes**	**No**
Loss of control of bladder?	**Yes**	**No**
Dark colored urine?	**Yes**	**No**
Trouble holding urine?	**Yes**	**No**
Passed a kidney stone?	**Yes**	**No**

Hematologic

Do you frequently have bleeding gums?	**Yes**	**No**
Have you recently had increased bruising?	**Yes**	**No**
Do you tend to "bleed freely"?	**Yes**	**No**

G.I.
Have you recently had pain in the stomach which:

Occurs one to two hours after eating?	**Yes**	**No**
Awakens you at night?	**Yes**	**No**
Is brought on by eating fried or gassy foods?	**Yes**	**No**
Is relieved by antacid medications?	**Yes**	**No**
Is relieved by bowel movements?	**Yes**	**No**
Occurs while eating or immediately after?	**Yes**	**No**
Loss of appetite?	**Yes**	**No**
Blood in stools or black stools?	**Yes**	**No**
Cramping pain in abdomen?	**Yes**	**No**

Alternating diarrhea and constipation?	**Yes**	**No**
Pain during and after bowel movement?	**Yes**	**No**
Required use of laxative or enemas?	**Yes**	**No**

Musculoskeletal

Have you ever experienced back trouble or injury?	**Yes**	**No**
Loss of feeling or numbness?	**Yes**	**No**
Staggered gait?	**Yes**	**No**
Phlebitis or inflamed leg veins?	**Yes**	**No**
Paralysis or weakness of limbs?	**Yes**	**No**
Swollen or painful joints?	**Yes**	**No**
Varicose veins?	**Yes**	**No**
Pain in big toe?	**Yes**	**No**

Cardiovascular

Have you ever experienced shortness of breath?	**Yes**	**No**
If yes, when and what seemed to bring it on? _____		
Have you ever experienced chest pain?	**Yes**	**No**
If yes, when and what seemed to bring it on? _____		
Have you ever experienced palpitations?	**Yes**	**No**
If yes, when and what seemed to bring it on? _____		
Have you ever experienced swelling in the ankles?	**Yes**	**No**
If yes, when and what seemed to bring it on? _____		
Do you have a pacemaker?	**Yes**	**No**

To be answered by men only:

Loss of sexual activity?	**Yes**	**No**
Prostate issues?	**Yes**	**No**
Discharge from penis?	**Yes**	**No**

To be answered by women only:

Are you still having regular monthly menstrual periods?	**Yes**	**No**
Have you ever had bleeding between periods?	**Yes**	**No**
Do you have very heavy bleeding with your periods?	**Yes**	**No**
Do you feel bloated and irritable before your period?	**Yes**	**No**
Are you now on or have you ever taken birth control pills?	**Yes**	**No**
Have you ever had a miscarriage?	**Yes**	**No**
Have you ever had discharge from the nipple of your breast?	**Yes**	**No**
Do you regularly have the cancer test of the cervix?	**Yes**	**No**

How many children born alive? _____ **How many miscarriages?** _____
How many stillbirths? _____ **How many cesarean operations?** _____
How may premature births? _____ **Any complication of pregnancy?** _____
Date of last menstrual period? _____

Detailed list of Medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Additional comments:

_____
_____
_____
_____