MAYFAIR INTERNAL MEDICINE, P.C.
6311 E. 14th Ave. Denver, CO 80220

Name: ____________________________ **Date:** ____________________________	**Reason for Visit:**

Personal Health History

Health Problems, Hospitalization, Surgery	Year started	Hospital if applicable

Current Medications (prescription or over the counter)

Name of Drug	Strength	Frequency Taken

Allergies to medications

Name of Drug	Reaction You Had

FAMILY HEALTH HISTORY (check the appropriate box)

	PARENTS	GRANDPARENTS	SIBLINGS	CHILDREN
HEART DISEASE				
HYPERTENSION				
STROKE				
CANCER (what type)				
DIABETES				
MENTAL ILLNESS				
GALLSTONES				

Personal Health History Page 2 Name____

HEALTH HABITS	
Do you exercise?	☐ **Yes** ☐ **No** **If yes, what?**
Diet (Any Followed?)	☐ **Yes** ☐ **No** **If yes, what?**
Do you smoke or use tobacco?	☐ **Yes** ☐ **No** **If yes, how many packs (or tobacco product) per day?** **How long (years)**
Do you drink alcohol?	☐ **Yes** ☐ **No** **If yes, what kind?** **Amount?** **How often?**
Sleep difficulty?	☐ **Yes** ☐ **No (describe)**
Recreational Drug Use?	☐ **Yes** ☐ **No** **If yes, what kind?** **Amount?**

PAST MEDICAL HISTORY					
☐	Headaches	☐	Heart failure	☐	Kidney problems
☐	Hypertension	☐	Allergies/ Hay fever	☐	Anemia
☐	Stroke	☐	Asthma	☐	Gout
☐	Epilepsy	☐	Shortness of breath	☐	Diabetes
☐	Fatigue	☐	Emphysema	☐	Arthritis
☐	Heart murmur	☐	Liver disease	☐	Thyroid trouble
☐	Chest pain/ Angina	☐	Ulcer	☐	Anxiety
☐	Dizziness	☐	Gastrointestinal disorder	☐	Depression
☐	Calf pain/ Claudication	☐	Milk intolerance	☐	Skin rashes or problems
☐	Heart Attack	☐	Constipation	☐	Other
☐	Elevated cholesterol	☐	Diarrhea		

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis A	☐ Influenza
	☐ Hepatitis B	☐ Zostavax

WOMEN ONLY		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Are you planning pregnancy?	☐ Yes	☐ No
Any menstrual irregularities?	☐ Yes	☐ No

OTHER PROBLEMS
If there are any other problems or you need more room to write than provided above, use this space.