OCOTILLO™ INTERNAL MEDICINE ASSOCIATES

Medical History

Patient Name____________________________________ **Date of Visit**_________________________

****PLEASE CHECK IN 15 MINUTES PRIOR TO APPOINTMENT WITH FORMS COMPLETED****

Primary Provider at Ocotillo Internal Medicine

☐ Jonathan Hackenyos, D.O.

☐ Cheryl Maurice, M.D.

☐ Drew V. Hall, M.D.

☐ Lily H. Delatte, MD

Other Physicians you see:

1.
2.
3.
4.
5.

Medications

(Please list all prescribed or over the counter medications)

Name of Medication	Dose (mg, ml)	# of tablets or capsules each dose	# of times per day
Example- Drug A	*20 mg*	*One tablet*	*Twice a day*

Medication Allergies

Have you had an allergic or adverse reaction to any medication? ☐ **Yes—complete details below**
☐ No

Medication	Type of Reaction

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Your Medical History

Check all that apply

- ☐ Hayfever (allergies)
- ☐ Hearing Loss
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Other ear or eye disease__________________

- ☐ Asthma
- ☐ COPD
- ☐ Valley Fever
- ☐ Lung Nodule
- ☐ Other lung disease_____________________

- ☐ High blood pressure (hypertension)
- ☐ Heart Attack (myocardial infarction)
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Elevated cholesterol (hypercholesterolemia)
- ☐ Other heart disease___________________

- ☐ Acid reflux (GERD)
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ IBS (irritable bowel syndrome)
- ☐ Hepatitis (type)___________________
- ☐ Ulcer of stomach or esophagus
- ☐ Chronic constipation
- ☐ Other gastrointestinal illness_____________

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Other rheumatologic disorder____________

- ☐ Cancer (type)_______________________

- ☐ Diabetes Mellitus
- ☐ Hypothyroidism (low thyroid)
- ☐ Hyperthyroidism (high thyroid)
- ☐ Menopause____age (women only)
- ☐ Polycystic ovarian disorder (women only)
- ☐ Other endocrine disease_______________

- ☐ Kidney disease
- ☐ Kidney stones (nephrolithiasis)
- ☐ Enlarged Prostate (men only)
- ☐ Frequent urinary tract infections
- ☐ Other kidney disease_________________

- ☐ Stroke or TIA
- ☐ Migraine Headaches
- ☐ Seizures
- ☐ Dementia
- ☐ Parkinson's Disease
- ☐ Other neurological disease_______________

- ☐ Skin cancer
- ☐ Eczema
- ☐ Other skin disease_______________

- ☐ Anemia
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Blood clot
- ☐ Other blood disorder_________________

- ☐ Depression
- ☐ Anxiety
- ☐ Eating Disorder
- ☐ Attention Deficit Disorder
- ☐ Bipolar Disease
- ☐ Other psychiatric illness_______________

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Surgical History		
☐ Appendectomy ☐ Removal of gallbladder (cholecystectomy) ☐ Colon surgery ☐ Breast surgery ☐ Prostate surgery	☐ Tubal ligation ☐ Vasectomy ☐ Hysterectomy ☐ Removal of ovaries (oophorectomy) ☐ Joint replacement-specify	☐ Cardiac Bypass ☐ Pacemaker ☐ Valve replacement ☐ Cardiac cath with stent ☐ Other (specify)_____________________

Family History

Family Member	**Living**	**Deceased/Age**	**Medical Problems/Cause of Death**
Mother			
Father			
	Total Living	**Total Deceased**	Medical Problems/Cause of Death
Sister(s)			
Brother(s)			
Son(s)			
Daughters(s)			
Other illnesses in the family, please specify:			

Social History

Who do you live with? ☐ Self ☐ Spouse ☐ Family ☐ Other, please specify

Exercise: ☐ No ☐ Yes, please specify type and frequency

Alcohol: ☐ No ☐ Yes, please specify type and frequency

Caffeine: ☐ No ☐ Yes, please specify type and frequency

Do you currently smoke? ☐ No ☐ Yes,
How much do you smoke?______________________________
How many years have you been smoking? ________________

Have you ever smoked? ☐ No ☐ Yes,
How many years did you smoke?_________________________
What year did you quit?__________________________________

Occupation:
☐ Check if retired and previous profession

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Immunizations			
Immunization	**Date**	**Immunization**	**Date**
☐ Influenza		☐ Pneumovax	
☐ Shingles (Shingrix)		☐ Prevnar 13	
☐ Shingles(Zostavax)		☐ Gardisil	
☐ Hepatitis B		☐ Tetanus	
☐ Hepatitis A		☐ TDAP	

Screening Male and Female			
☐ Stool Cards	Date	☐ Normal	☐ Abnormal
☐ Colonoscopy	Date	☐ Normal	☐ Abnormal
☐ Bone Density	Date	☐ Normal	☐ Abnormal

Screening Male			
☐ PSA	Date	☐ Normal	☐ Abnormal
☐ Testicular Exam	Date	☐ Normal	☐ Abnormal

Screening Female			
☐ Pap Smear	Date	☐ Normal	☐ Abnormal
☐ Mammogram	Date	☐ Normal	☐ Abnormal

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Review of Systems

Only circle any symptoms you are currently having or have had and are concerned about.

General	HEENT		Heart/Vascular	Respiratory
Weight loss	Visual changes	Nose congestion	Chest pain	Shortness of breath
Weight gain	Photophobia	Nose drainage	Rapid heart rate	Coughing
Fever	Eye itching	Nose bleeding	Irregular heart rhythm	Wheezing
Chills	Eye Redness	Sinus congestion	Leg swelling	Snoring
Fatigue	Loss of hearing	Sore throat	Pain in the legs when walking	
Insomnia	Ear infection	Hoarse Voice		

Gastrointestinal	Blood Disorder	Musculoskeletal	Skin
Stomach pain	Bleeding disorder	Joint pain	Rash
Nausea/vomiting	Easy bruising	Joint swelling	Hives
Heartburn	Anemia	Muscle pain	Dry skin
Trouble swallowing	**Lymphatics**	Back pain	Eczema
Diarrhea	Enlarged lymph nodes	Neck pain	Skin cancer
Constipation	Lymphedema	Fractures	
Blood in stool			
Stool incontinence			
Hemorrhoids			

Nervous System	Psychiatric	Genitourinary	Men
Dizziness	Depression	Burning with urination	Difficulties with urination
Spinning	Anxiety	Frequent urination	Weak stream
Numbness/tingling	Phobias	Nighttime urination	Scrotal/testicular lump
Gait disturbance	Eating disorder	Urinary incontinence	STD.s
Balance difficulties	Substance Abuse	Blood in the urine	
Seizures		Sexual difficulties	
Headaches			

Pre Menopause	Post Menopause	Breast
Irregular menses	Vaginal dryness	Breast lumps
Painful menses	Hot flashes/night sweats	Nipple Discharge
Vaginal discharge	Vaginal Bleeding	
STD's	STD's	
LMP______		