South Denver Internal Medicine
A Concierge Medical Practice
Charles H. Miranda, MD, FACP

10459 Park Meadows Dr, #101
Lone Tree, CO 80124
Phone: 303-799-8890
Fax: 303-799-8891
www.southdenvermedicine.com

ADULT HEALTH HISTORY

Name: **Date:**

Age: **Date of Birth:** **Female** ☐ Male ☐

Who or how were you referred to our practice?

What is the main reason for today's visit?

1. PAST MEDICAL HISTORY

MARK CONDITIONS YOU HAVE OR HAVE HAD

CONDITION	YEAR	CONDITION	YEAR	CONDITION	YEAR
Acid Reflux (GERD) ☐		Eczema ☐		Mumps ☐	
Alcoholism ☐		Gastritis ☐		Osteoarthritis ☐	
Alzheimer's ☐		Glaucoma ☐		Osteoporosis ☐	
Anemia ☐		Goiter ☐		Pap Smear Abnormal ☐	
Anorexia ☐		Gonorrhea ☐		Parkinson's ☐	
Anxiety ☐		Gout ☐		Pneumonia ☐	
Arthritis ☐		Heart Attack (MI) ☐		Polio ☐	
Asthma ☐		Heart Murmur ☐		Prostate Cancer ☐	
Atrial Fibrillation ☐		Hemorrhoids ☐		Prostate Enlarged ☐	
Back Pain ☐		Hepatitis B ☐		Rheumatoid Arthritis ☐	
Bipolar ☐		Hepatitis C ☐		Rheumatic Fever ☐	
Bleeding Disorder ☐		Hernia (Hiatal) ☐		Seizures (Epilepsy) ☐	
Blood Clot Leg (DVT) ☐		Hernia (Inguinal) ☐		Shingles ☐	
Blood Clot Lung (PE) ☐		Herpes ☐		Sinusitis ☐	
Blood Transfusion ☐		High Blood Pressure ☐		Sleep Apnea ☐	
Breast Cancer ☐		High Cholesterol ☐		Stomach Ulcers ☐	
Breast Lump ☐		HIV Positive ☐		Stroke ☐	
Bulimia ☐		Hypothyroid (low) ☐		Syphilis ☐	
Cataracts ☐		Hyperthyroid (high) ☐		TB Skin Test -positive ☐	
Celiac Disease ☐		Incontinence-urinary ☐		Tuberculosis ☐	
Chicken Pox ☐		Infertility ☐		Urinary infections recurrent ☐	
Cirrohsis ☐		Kidney Failure ☐		Vertigo ☐	
COPD/Emphysema ☐		Kidney Stones ☐		**Other Medical Conditions:**	
Coronary Artery Disease ☐		Lung Cancer ☐		1.	
Depression ☐		Lupus ☐		2.	
Diabetes Type I (Child) ☐		Measles ☐		3.	
Diabetes Type II (Adult) ☐		Melanoma ☐		4.	
Diverticulitis ☐		Migraines ☐		5.	

2. PAST SURGERIES

MARK SURGERIES YOU HAVE OR HAVE HAD

SURGERY	YEAR	SURGERY	YEAR	SURGERY	YEAR
Angioplasty with Stent ☐		Colon Resection ☐		Knee Replaced ☐	
Heart Valve Surgery ☐		Coronary Bypass ☐		Lumpectomy ☐	
Appendectomy ☐		Gallbladder (cholecystectomy) ☐		Mastectomy ☐	
Back Surgery-Discectomy ☐		Gastric Bypass ☐		Mohs for skin cancer ☐	
Back Surgery-Fusion ☐		Hemorrhoidectomy ☐		Pacemaker ☐	
Bronchoscopy ☐		Hernia Repair ☐		Prostate Removed ☐	
C-Section ☐		Hip Replaced ☐		Rotator Cuff Repair ☐	
Carotid Endarterectomy ☐		Hysterectomy & ovaries removed ☐		Tonsillectomy ☐	
Carpal Tunnel ☐		Hysterectomy (uterus removed) ☐		Tubal Ligation ☐	
Cataract ☐		Knee Arthroscope ☐		Vasectomy ☐	

Patient Name: _____ **Date:** _____

3. MEDICATIONS - LIST ANY MEDICATIONS or SUPPLEMENTS YOU TAKE

Medications, Vitamins and Herbs	Dose	Times /day

Medications, Vitamins, and Herbs	Dose	Times /day

4. ALLERGIES TO MEDICINES

Name of Medication	List Allergy or Reaction

5. HEALTH MAINTENANCE

	Date
Bone density	
Calcium Heart Score	
CAT scan Chest (smokers)	
Colonoscopy	
Mammogram (women only)	
Pap smear (women only)	

6. SOCIAL HISTORY

Work History: Currently Working ☐ Retired ☐	**Current or Former Occupation:**

Married ☐	Divorced ☐	Widowed ☐	Single ☐

Do you **exercise** on a regular basis?	Yes ☐	No ☐	
How many days do you exercise per week?			
Type of exercise?			
Do you drink **alcohol** on a regular basis?	Yes ☐	No ☐	
Number of drinks per week?			
Do you **CURRENTLY** use **tobacco**?	Yes ☐	No ☐	
Year you started smoking tobacco?			
Cigarettes?	Yes ☐	No ☐	Packs/day?
Cigars?	Yes ☐	No ☐	#/week?
Chewing Tobacco?	Yes ☐	No ☐	Cans/week
Vaping?	Yes ☐	No ☐	Amount?

Have you smoked tobacco in the PAST?	Yes ☐	No ☐
Year you started smoking?		
Year you quit smoking?		
Do you or have you used **illicit drugs?**	Yes ☐	No ☐
Does **stress** affect your health?	Yes ☐	No ☐

Describe your **diet**? (Check all that apply)			
Needs to Improve ☐		Low Cholesterol/Fat ☐	
Healthy ☐		Low carbohydrate ☐	
Diabetic ☐		Gluten free ☐	
Intermittent Fasting ☐		Vegetarian/VEGAN ☐	

7. FAMILY HISTORY

Mark if your blood relatives have had any of these conditions

Condition		Relation to you
Alcoholism	☐	
Alzheimer's	☐	
Anemia	☐	
Anxiety	☐	
Asthma	☐	
Bleeding disorder	☐	
Breast cancer	☐	
Celiac disease	☐	
Crohn's disease	☐	
Colon cancer	☐	
Depression	☐	
Diabetes	☐	
Heart attack	☐	
Heart disease	☐	
High blood pressure	☐	
High cholesterol	☐	
Kidney disease	☐	
Lung cancer	☐	
Lupus	☐	
Melanoma	☐	
Migraines	☐	
Osteoporosis	☐	
Prostate cancer	☐	
Rheumatoid arthritis	☐	
Stroke	☐	
Seizures	☐	
Thyroid disease	☐	

Patient Name: _____ Date: _____

8. REVIEW OF SYSTEMS

Mark if you CURRENTLY have or have had within the last FEW WEEKS any of the symptoms below.

GENERAL	HEART	URINARY	PSYCHIATRY
☐ Abnormal bleeding	☐ Chest discomfort/pain	☐ Blood in urine	☐ Anxiety
☐ Abnormal bruising	☐ Difficulty breathing @ night	☐ Cloudy urine	☐ Depression
☐ Chills	☐ Exercise intolerance	☐ Inability to control bladder	☐ Hallucinations
☐ Cold intolerance	☐ Leg cramps with exercise	☐ Inability to empty bladder	☐ Suicidal thoughts
☐ Dizziness	☐ Lightheaded	☐ Frequent urination	☐ Violent thoughts
☐ Fainting episodes	☐ Palpitations/racing heart	☐ Lack of sexual drive	**MEN ONLY**
☐ Fatigue	☐ Short of breath with exercise	☐ Nighttime urination	☐ Erection problems
☐ Fever	☐ Swelling (legs or feet)	☐ Burning/painful urination	☐ Lump in testicle
☐ Flushing	**LUNGS**	☐ Urinary urgency	☐ Penis discharge
☐ Heat intolerance	☐ Breathing problems	☐ Weak urinary stream	☐ Sore on penis
☐ Insomnia	☐ Cough	**MUSCLES AND JOINTS**	**WOMEN ONLY**
☐ Loss of appetite	☐ Coughing up blood	☐ Back pain	☐ Abnormal PAP
☐ Lymph node enlarged	☐ Coughing up mucus	☐ Joint pain	☐ Breast lump
☐ Night sweats	☐ Short of breath	☐ Joint swelling	☐ Breast pain
☐ Sleep disturbance	☐ Snoring	☐ Morning joint stiffness	☐ Heavy periods
☐ Weight gain	☐ Wheezing	☐ Muscle cramps/pain	☐ Hot flashes
☐ Weight loss	**GASTROINTESTINAL**	☐ Muscle weakness	☐ Irregular periods
EYES	☐ Abdominal pain	**SKIN**	☐ Nipple discharge
☐ Blurry vision	☐ Black tarry stools	☐ Change in moles	☐ Painful intercourse
☐ Double vision	☐ Bloating	☐ Excessive dry skin	☐ Painful periods
☐ Dry eyes	☐ Bloody stools	☐ Hair loss	☐ Pelvic Pain
☐ Eye discharge	☐ Change in bowel habits	☐ Hives	☐ Vaginal discharge
☐ Eye pain	☐ Constipation	☐ Itching	☐ Vaginal itching
☐ Floaters	☐ Diarrhea	☐ Nail changes	☐ Vaginal sores
☐ Light sensitivity	☐ Gas, excessive	☐ Rash	
☐ Vision loss	☐ Heartburn & indigestion	☐ Skin cancer	
EAR, NOSE AND THROAT	☐ Hemorrhoids	☐ Sores non-healing	
☐ Bleeding gums	☐ Nausea	**NEUROLOGY**	
☐ Earache	☐ Swallowing difficulty	☐ Concentration difficulty	
☐ Ear discharge	☐ Swallowing pain	☐ Falls	
☐ Hearing loss	☐ Vomiting	☐ Headaches	
☐ Hoarseness	☐ Vomiting blood	☐ Numbness or tingling	
☐ Nasal congestion	☐ Yellow skin/eyes color	☐ Paralysis	
☐ Nosebleeds	**ENDOCRINE**	☐ Poor balance	
☐ Ringing in the ears	☐ Skin color has changed	☐ Seizures	
☐ Seasonal allergies	☐ Sweating, excessive	☐ Speech difficulty	
☐ Sore throat	☐ Thirst, excessive	☐ Tremors	
☐ Vertigo or room spins	☐ Unusual hair distribution	☐ Weakness	