GRANGER MEDICAL CLINIC

**Granger Wasatch Internal Medicine**
1160 E. 3900 S., Ste. 1000, Salt Lake City, UT 84124
**office** 801.262.1771

Patient Name: _____ DOB: _____ Acct. #: _____

*****PLEASE BRING A COMPREHENSIVE LIST OF ALL YOUR MEDICATIONS, OR BRING YOUR MEDICATIONS WITH YOU, TO YOUR APPOINTMENT*****

## Family History

Has anyone in your family had any of the following? (Please indicate who, and don't include yourself.)

| | | | |
|---|---|---|---|
| ☐ Heart attack | ☐ High cholesterol | ☐ Bipolar Disorder | ☐ Depression |
| ☐ Congestive heart failure | ☐ Thyroid problems | ☐ High blood pressure | ☐ Osteoporosis |
| ☐ Other mental health disorder | ☐ Other heart disease | ☐ Diabetes | ☐ Colon cancer |
| ☐ Asthma | ☐ Arthritis | ☐ Breast cancer | ☐ Emphysema |
| ☐ Rheumatoid Arthritis | ☐ Ovarian cancer | ☐ Other lung disease | ☐ Migraine headaches |
| ☐ Prostate cancer | ☐ Liver disease | ☐ Stroke | ☐ Alcoholism |
| ☐ Kidney disease/disorders | ☐ Other cancer: _____ | | ☐ Other: _____ |

## Social History

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Employment: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Homemaker ☐ Retired

What kind of work do you do? _____

Do you smoke? ☐ Yes ☐ No How much of a pack per day? _____ Since what age? _____

☐ Former Smoker: Year quit: _____ Started at age: _____ How much of a pack per day? _____

Do you Vape? ☐ Yes ☐ No Do you use chewing tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Never ☐ 0-2/Day ☐ 2-4/Day ☐ More: _____/Day

How often do you have alcohol? ☐ 1-2 Occasional ☐ Several on Occasion ☐ Heavily on Occasion

Do you drink caffeine? ☐ Coffee ☐ Soda ☐ Tea ☐ Energy Drinks How many cups/cans per day? _____

Do you use drugs? ☐ Yes ☐ No ☐ In the past only Which drugs? _____

Do you exercise regularly outside of your daily work or school responsibilities? ☐ Yes ☐ No

How many days per week? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Everyday ☐ Occasional ☐ None

## Allergies

Please list any allergies you may have to medications or food:

_____

_____

_____

## Surgical History

Please mark all that apply for your entire life:

| | | | | | |
|---|---|---|---|---|---|
| ☐ Appendectomy | ☐ Tonsillectomy | ☐ Gall bladder | ☐ Wisdom teeth | ☐ Cataracts | ☐ Vasectomy |
| ☐ Cesarean section | ☐ Sinus surgery | ☐ Hysterectomy | ☐ Tubal ligation | ☐ Joint replacement | |
| ☐ Knee surgery | ☐ Shoulder surgery | ☐ Ankle surgery | ☐ Foot surgery | ☐ Carpal tunnel | ☐ Jaw |

☐ Please list any other surgeries: _____

_____

**Hospitalizations**

Have you ever been in the hospital over night? (This does not include ER visits.) ☐ Yes ☐ No

If yes, what where you hospitalized for? _____

**Health Maintenance**

Men: When was your last prostate check? _____

When was your last PSA test (blood test for prostate cancer)? _____

Women: When was your last PAP test? _____

When was your last mammogram? _____

When was your last breast exam? _____

Do you do self-breast exams regularly? ☐ Yes ☐ No

When was your last flu shot? _____ When was your last tetanus shot? _____

Have you had the COVID-19 vaccine? ☐ Yes ☐ No

If yes, which vaccine? ☐ Johnson & Johnson ☐ Moderna ☐ Pfizer

If you are over 65, or have a chronic illness, when was your last pneumonia shot? _____

If you are 50 or older, or have a family history of colon cancer, have you had a colonoscopy? ☐ Yes ☐ No

**Review of Symptoms**

Over the past two weeks, have you had or experienced any of the following?

| | | | | |
|---|---|---|---|---|
| ☐ Fatigue | ☐ Cough | ☐ Abnormal menses | ☐ Low back pain | ☐ Appetite loss |
| ☐ Chills | ☐ Heartburn | ☐ Vaginal discharge | ☐ Sensory changes | ☐ Excessive thirst |
| ☐ Vomiting | ☐ Belly pain | ☐ Shortness of breath | ☐ Diarrhea | ☐ Leg pain with exercise |
| ☐ Palpitations | ☐ Chest pain | ☐ Ringing in ears | ☐ Breast pain | ☐ Weight change |
| ☐ Headaches | ☐ Rash | ☐ Vision problems | ☐ Hearing Loss | ☐ Pain with intercourse |
| ☐ Breast lump | ☐ Anxiety | ☐ Excessive thirst | ☐ Yellow skin | ☐ Black or tar-like stool |
| ☐ Constipation | ☐ Depression | ☐ Changes in mole | ☐ Blood in stool | ☐ Blood in urine |
| ☐ Joint pains | ☐ Fever | ☐ Joint swelling | ☐ Sensory changes | ☐ Convulsion/Seizures |
| ☐ Change in urine habits | | ☐ Tingling/numbness | ☐ Vaginal itching/burning | |
| ☐ Swelling in legs/ankles | | ☐ Other: _____ | | |

**Other Medical Providers**

Do you see any other medical providers at this time? ☐ Yes ☐ No If yes, please list below:

| | |
|---|---|
| Asthma/Allergy | Provider Name: _____ |
| Cardiology | Provider Name: _____ |
| Dermatology | Provider Name: _____ |
| Ear, Nose, & Throat | Provider Name: _____ |
| Endocrinology | Provider Name: _____ |
| General Surgery | Provider Name: _____ |
| Gastroenterology | Provider Name: _____ |
| Nephrology | Provider Name: _____ |
| Neurology | Provider Name: _____ |
| OB/GYN | Provider Name: _____ |
| Oncology | Provider Name: _____ |
| Ophthalmology | Provider Name: _____ |
| Orthopedics | Provider Name: _____ |
| Pain Management | Provider Name: _____ |
| Podiatry | Provider Name: _____ |
| Pulmonology/Sleep | Provider Name: _____ |
| Rheumatology | Provider Name: _____ |
| Urology | Provider Name: _____ |
| Other Specialty | Provider Name: _____ |