ARIZONA INTERNISTS

New Member Health History

6565 E Greenway Pkwy Ste 102, Scottsdale, Arizona 85254 Phone (480) 900-7595 Fax (480) 739-0262
Michael Germain, M.D. & Danielle Wicklow, M.D.

Type into this form or print and complete by hand. Bring it to your first appointment or upload it with your code.

PATIENT INFORMATION

Legal Name

Date of Birth (MM/DD/YYYY)

Sex: ◯ Male ◯ Female

Select Doctor: ◯ Michael Germain, M.D. ◯ Danielle Wicklow, M.D.

Have you completed your advanced directives, living will, and power of attorney? ◯ Yes ◯ No

MEDICATION ALLERGIES

☐ No known medication allergies

	Allergy	Reaction
1		
2		
3		
4		

MEDICATION LIST

	Medication	Instructions	Needs refill
1			☐
2			☐
3			☐
4			☐
5			☐
6			☐
7			☐
8			☐
9			☐
10			☐

SPECIALISTS

	Specialty	Name	Phone / Fax
1			
2			
3			
4			
5			
6			

MEDICAL DIAGNOSES

Heart and Vascular
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heartbeat
- ☐ Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Murmur
- ☐ Leg Swelling
- ☐ Varicose Veins
- ☐ Blood Clot (DVT)

Metabolic and Hormone
- ☐ Pre-Diabetes
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Low Testosterone
- ☐ Menopause Symptoms
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ Obesity
- ☐ Abnormal Calcium / Parathyroid
- ☐ Abnormal Adrenal Gland Function (Addison's)

Lung
- ☐ Asthma
- ☐ COPD
- ☐ Pulmonary Hypertension
- ☐ Sleep Apnea
- ☐ Pulmonary Embolism (PE)
- ☐ Lung Nodule
- ☐ Valley Fever
- ☐ Tuberculosis

Cancer
- ☐ Breast Cancer
- ☐ Prostate Cancer
- ☐ Colon Cancer
- ☐ Skin Cancer
- ☐ Lung Cancer
- ☐ Bladder/Ureter Cancer
- ☐ Leukemia / Lymphoma

Blood and Nutrients
- ☐ Chronic Anemia
- ☐ Low Iron
- ☐ Hemochromatosis (High Iron)
- ☐ Low B12
- ☐ Low Vitamin D
- ☐ Low Platelets
- ☐ Elevated Platelets

Eyes, Ears, and Sinus
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glaucoma (Elevated Eye Pressure)
- ☐ Hearing Loss
- ☐ Tinnitus
- ☐ Dizziness or Vertigo
- ☐ Chronic Sinus Infections

Brain, Nerves, and Spine
- ☐ Migraines
- ☐ Neuropathy / Nerve Pain
- ☐ Restless Legs
- ☐ Tremor
- ☐ Stroke / TIA
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ Parkinsons
- ☐ Dementia / Cognitive Impairment
- ☐ Chronic Back Pain
- ☐ Degenerative Spine Disease
- ☐ Balance Disorder / Hx of Falls

Skin
- ☐ Psoriasis
- ☐ Eczema
- ☐ Fungal Infections
- ☐ Rosacea
- ☐ Squamous Cell Skin Cancer
- ☐ Basal Cell Skin Cancer
- ☐ Melanoma

Gastrointestinal
- ☐ Acid Reflux / GERD
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Fatty Liver
- ☐ Liver Disease
- ☐ Chronic Constipation
- ☐ Celiac Disease
- ☐ Ulcer
- ☐ Inflammatory Bowel Disease
- ☐ H. Pylori

Kidneys and Urine
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Enlarged Prostate
- ☐ Elevated Prostate Specific Antigen (PSA)
- ☐ Frequent Bladder Infections (UTIs)
- ☐ Blood in Urine
- ☐ Protein in Urine
- ☐ Interstitial Cystitis

Bone, Joints, and Autoimmunity
- ☐ Osteoarthritis
- ☐ Low Bone Density
- ☐ Gout
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Joint Replacement
- ☐ Psoriatic Arthritis
- ☐ Sjogren's Disease
- ☐ Raynaud's

Other diagnoses

SURGERIES

- ☐ Appendectomy
- ☐ Bariatric Surgery
- ☐ Brain Surgery
- ☐ Breast Surgery
- ☐ Heart Stents
- ☐ Valve Replacement
- ☐ CABG (Heart Bypass)
- ☐ Caesarean Section
- ☐ Gallbladder Removal
- ☐ Colon Surgery
- ☐ Cosmetic Surgery
- ☐ Eye Surgery
- ☐ Fracture Surgery
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Prostate Surgery
- ☐ Spine Surgery
- ☐ Tubal Ligation
- ☐ Vasectomy

Other Surgeries

Surgical Complications

OTHER HISTORY

Prior Hospitalizations

Military Service History / Health-related issues or exposures

Dietary Limitations

Tobacco / Nicotine History

Alcohol History

FAMILY HISTORY

Relative	Medical conditions
Mother	
Father	
Sisters	
Brothers	
Daughter	
Son	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	
Other	

SCREENING

Last Breast Cancer Screening

Last Cervical Cancer Screening

Last Colonoscopy / Colon Cancer Screening

Last Coronary Calcium Score

Last Carotid Ultrasound

Last Bone Density Scan (DEXA)

PATIENT CONFIRMATION

I confirm that this health history is accurate and complete to the best of my knowledge.

Signature of Patient or Patient's Authorized Representative

Date

Printed Name

Relationship to Patient or Description of Authority to Act for Patient (if applicable)