COMPREHENSIVE HISTORY QUESTIONNAIRE AND PHYSICAL EXAM

Name_____ **Birthdate** ____/____/____ **Today's Date** _____

CURRENT MEDICAL PROBLEMS:

Please list the medical problem for which you came to see the doctor. About when did they begin?

Problem(s)	Date Began

CURRENT MEDICATIONS:

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin, cold tablets or vitamin supplements). List name, dosage, and times per day.

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

CURRENT ALLERGIES, SENSITIVITIES AND INTOLERANCES or circle ***NO KNOWN ALLERGIES***:

List anything that you are allergic to such as certain foods, medications, dust, chemicals, soaps, household items, pollens, bee stings, etc., and indicate how each affects you. _____

_____

ARE YOU DIABETIC? _____ **NO** _____ **YES** **ALLERGIC TO LATEX?** _____ **NO** _____ **YES**

OTHER MEDICAL CARE:

If you are being treated for any other illnesses or medical problems by another physician or mental health practitioner, please describe the problems and write the name of the physician, health practitioner or medical facility treating you.

Illness or Medical Problem	Physician or Medical Facility	City

TOBACCO USE HISTORY

Current smoker _____ Yes _____ No If yes, number of packs per day _____
Previous smoker _____ Yes _____ No If so, quit when _____
Other tobacco use _____

We encourage our patients to discontinue tobacco use because of the health risks associated with it.

ALCOHOL USE: Describe how much per day _____

PATIENT/MD/PROVIDER CHECK LIST FOR MEDICAL HISTORY

PAST SURGERIES: None _____
List here any past surgeries with approximate age.

ACCIDENTS: No injuries of consequence _____
List any serious injuries, with approximate age.

PAST ILLNESSES: No serious past illnesses _____
List any serious illnesses, with approximate age.

List childhood diseases.

Sexually transmitted diseases.

FAMILY HISTORY: If any of the following have run in your family, check the appropriate block.
Allergies ____ Cancer ____ Tuberculosis ____ Diabetes ____ Heart disease ____ Strokes ____ Hypertension ____

REVIEW OF SYMPTOMS: Please circle any of the following that apply to you.

1. HEAD AND NECK

Headaches	Vision glasses	Failing vision	Eye pain	Double vision
See floating lights	Severe hearing loss	Ringing in ears	Pain in ears	Discharge from ears
Repeated nosebleeds	Teeth problems	Chronic nose obstruction	Chronic sore tongue	Persistent sore gums
Prolonged hoarseness	Frequent colds	Persistent neck rigidity	Swelling in tongue	

2. HEART- CARDIOVASCULAR

Heart problems Chest pain on effort Skipping/irregular heart beats Ankles swell Hypertension Difficult breathing

3. PULMONARY - LUNGS

Sit up to breathe easier Spit up blood Wheezing Have chronic cough Frequent chest colds Have night sweats

4. STOMACH AND INTESTINES

Chronic abdominal pain	Vomit blood	Any blood from rectum	Persistent nausea	Skin turns yellow
Clay-colored stools	Heartburn	Any chronic diarrhea	Habitual constipation	Appetite loss
Any black tarry stools	Have hemorrhoids	Weight loss		
Pain with bowel movements			Trouble swallowing/food sticking	

5. URINARY TRACT, ETC.

Frequent urination	Pain with urination	Hard to start urinary flow	Any leakage of urine	Frequent night urination
Passed any stones	Any blood in urine	Any bed wetting	Scanty urination	Any retention of urine

OB/GYN (for women only)
Last menstrual period_____ Painful menstruation Excess menstruation Bleed between periods
Any missed periods Number of pregnancies _____ Number of living children ____

6. MUSCLES/JOINTS

Physically handicapped/limited	Joint or muscle problems	Shoulder pain	Back pain	Pain with walking
Any tingling sensations	Any numbness	Disturbance in walking	Any muscle jerking	
Any paralysis	Any shaking	Any strokes	Any seizures	

7. NEUROPSYCHOLOGICAL

Depression	Paralysis/weakness	Nervous breakdown	Any memory loss	Any mental problem
Dizzy spells	Personality changes	Speech disturbances	Psychotherapy/counseling	Any alcohol problem
Any drug problem		Serious marital problem		