MEDICAL HISTORY PLEASE UPDATE/PROVIDE INFORMATION SINCE YOUR LAST PHYSICAL

NAME_____ DATE OF BIRTH_____TODAYS DATE_____

Please fill out **completely** and provide details requested. Use a 3rd page if needed to answer any questions or provide additional information on issues you wish to discuss today.

Please describe any medical problems <u>you wish to discuss at this visit</u>

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Have there been any significant changes in your health since your last physical that we may not be aware of? If so please describe:_____

_____

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Current Medications - **PLEASE FILL OUT A SEPERATE FORM IN DETAIL LISTING PRESCRIPTION MEDICATION AND SUPPLEMENTS. It is important to fill this out with ALL the information.**

Have there been any new allergic reactions/ side effects to medication/ food/supplements since your last physical. If so, please describe the reaction (ex. rash)

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Social History/Other information Ethnicity _____

Marital status_____ Occupation_____ Who lives with you_____

What pets do you have at home? _____

Do you smoke cigarettes if so how much _____ if quit, when_____

Have you used any recreational/illicit drugs?_____

How much alcohol do you drink?_____

How much caffeine containing beverages do you drink? _____

How much water do you drink?_____

Describe your current exercise activities_____

Describe your current diet **in detail**

Breakfast _____

Lunch_____

Dinner_____

Snacks_____

Please note the date if you have had any of the following tests at another facility since your last physical:

Colonoscopy _____ **Pap smear**_____ **Rectal exam/Prostate exam**_____

Mammogram_____ **Breast exam by a health care provider**_____ **PSA**_____

Bone density scan_____ **Eye exam** _____ **Dental exam** _____

Other_____

FAMILY HISTORY: Please provide any new information which has occurred since your last physical.

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Name_____ D.O.B._____ Date_____
Please check if you are having a problem with any of the following now:

Fever____ Chills____ Fatigue____ Night sweats_____ Hot flush____ Weight loss____ Weight gain____
Changes in hair____ Weakness____ Rash____ Dry skin____
Changes in nails_____ Itching_____ New skin growths or changes of concern_____

Visual disturbance____ double vision____ Glaucoma____ Cataracts____ Eye pain____ Hearing loss____
Ringing in your ears____ ear pain____ Nasal congestion____ Nose bleeds____ Sinus problems____
Problems with your teeth/gums____ Hoarseness____ Sore throat____ Snoring_____
Neck pain____ Swollen "glands"____ Difficulty swallowing____ Thyroid problems____
Other problems with your eyes, ears, nose, throat, neck_____

Breast pain____ Breast lumps____ Nipple discharge____ Other breast problems_____

Cough____, Excessive or bloody sputum____ Wheezing____ Asthma____ Bronchitis____ Pneumonia_____
Other problems with your lungs/breathing_____

Palpitation____Arrythymia ____ Edema____ Shortness of breath (at rest or with exertion)____
Valvular heart disease____ Other heart problems_____

Leg pain/cramps_____ Phlebitis____ Back Pain____ Neck Pain____ Hip pain____ Groin pain____
Knee pain____ Arm or shoulder pain____Arthritis____ Gout____ Other musculoskeletal problems_____

Heartburn/indigestion____ change in appetite____ Nausea or vomiting____ Change in bowel habits _____
Constipation____ Diarrhea____ Blood in your stool ____ Black stools ____ Hepatitis____
Irritable bowel____ Colitis____ Gallstones____ Liver disease____ Hemorrhoids____ Abdominal pain____
Food intolerance____ History of Ulcer disease____Other intestinal problems_____

Anemia____ Excessive bleeding/bruising____ History of blood clots____ Other blood disorder_____

History of diabetes____ Excessive thirst or urination____ Intolerance to heat or cold____
Anxiety____ Depression____ Difficulty sleeping____ Other mood disturbance_____
Fainting____ Dizziness____ Seizure____ Stroke____ Tremors____ Localized weakness or numbness____
Problems with memory____ Headache_____Other neurologic problems_____

Urinary frequency/urgency____ Incontinence____ Urinary tract infection____ Blood in urine___
Kidney stones___ Other problems urinating or change in urination_____
History of a sexual transmitted disease if so, describe_____
Problems with sexual desire or function_____
Number of sexual partners in the past few years_____ Men / Women / Both_____
Females: Vaginal discharge____ Pain with intercourse____ Other problems_____
If still menstruating: My period occurs every _____ days and lasts for ____ days.Are your periods regular?
Yes/no ____Heavy Yes/no_____ Bleed in between actual period Yes/no____;severe cramps Yes/no___
check here if no longer having menstrual periods____; #of previous pregnancies___ Miscarriage/Abortion ___
Males: Pain in testicles/penis____ Penile discharge____ Prostate problems____ Other problems_____
Difficulty obtaining or maintaining an erection_____

Do you have a power of attorney for health care or advanced directives (ex. Living will)_____
Do you practice any relaxation techniques (ex. Meditation)_____
Do you have any spiritual beliefs, if so please describe_____

NAME _____ DATE _____/_____/_____

NAME OF MEDICATION/ VITAMINS/SUPPLIMENTS	DOSE (mg)	TIME taken	REASON TAKING	DR (who prescribed it)