

PULMONARY AND MEDICAL ASSOCIATES

Comprehensive Physical Evaluation

Name _____
Date of Appointment _____

Date of Birth _____
Place of Birth _____
Race _____
Primary language _____
Hispanic/Not Hispanic (circle one)

Please list the name of any other physicians/providers you see regularly:

Name _____

Past Medical History

Please list any medical problems that you have been diagnosed with:

Please list any surgeries and/or hospitalizations:

<u>Surgeries</u>	<u>Date</u>	<u>Hospitalizations</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

Mother	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	Father	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased
	Age: _____	Age at death: _____		Age: _____	Age at death: _____
Siblings (please specify)					
1. _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	2. _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased
	Age: _____	Age at death: _____		Age: _____	Age at death: _____
3. _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	4. _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased
	Age: _____	Age at death: _____		Age: _____	Age at death: _____

Do any family members or relatives have the following disorders?

Please indicate mother, father, brother(s), sister(s). For grandparents, aunts and uncles, please indicate mother's or father's side.

Breast cancer _____
Colon cancer _____
Prostate cancer _____
Lung cancer _____
Skin cancer _____
Mental illness (please specify) _____
High blood pressure _____

Heart disease _____
Lung disease _____
Gastrointestinal disease _____
Kidney disease _____
Diabetes _____
Other illnesses _____

**** PLEASE FILL OUT BACK OF THIS SHEET AND SECOND SHEET ****

Patient Name _____

Review of Systems – Please check off the box of any symptom/illness you have or have had in the past.

General

- Fatigue
- Fever
- Night Sweats
- Trouble sleeping
- Unexplained weight change

Skin

- Change in wart/mole
- Skin cancer
- New lesions
- Rashes/Psoriasis/Hives

HEENT

- Decreased hearing
- Ringing in ears/Tinnitus
- Sinus trouble/nasal congestion
- Hay fever/allergies
- Hoarseness
- Frequent ear infections
- Ear perforation
- Recurrent nosebleeds
- Recurrent tonsillitis
- Glaucoma
- Eye infections

Respiratory

- Coughing up blood
- Chronic cough
- Shortness of breath
- Snoring
- Tuberculosis/Positive skin test
- Pneumonia
- Asthma
- COPD
- Bronchitis

Cardiovascular

- Chest pain
- Swollen ankles
- Leg pain/cramps
- Palpitations/Irregular pulse
- Heart murmur
- Varicose veins
-

Gastrointestinal

- Abdominal pain

- Change in bowel habit
- Nausea/vomiting
- Diarrhea
- Difficulty swallowing
- Hemorrhoids
- Indigestion/Heartburn
- Rectal bleeding
- Bloody or tarry stools
- Loss of appetite
- Constipation
- Colitis
- Diverticulosis
- Gall bladder problem
- Jaundice/hepatitis
- Hernia

Male Genitourinary

- Change in urinary stream
- Weak erections
- Urethral discharge
- Increased urinary frequency
- Pain with urination
- Testicular mass/pain
- Overnight urination
- Decrease in force of urination
- Problems with control of urination
- Blood in urine
- DES exposure
- Varicocele
- Prostate infection

Female Genitourinary

- Date of last menstrual period: _____
- Change in bladder habits
- Increased urinary frequency
- Urinary urgency
- Irregular periods
- Pain/bleeding after sex
- Vaginal discharge
- Severe pain w/periods
- Menopausal symptoms (hot flashes, etc.)
- Breast disease

Musculoskeletal

- Chronic back pain

- Joint pain _____ (which joint(s)?)
- Muscle weakness/pain
- Recent injuries?

- Arthritis/Rheumatism
- Gout

Neurologic

- Decreased memory
- Frequent headache
- Migraine headache
- Numbness/Tingling
- Weakness
- Seizures/convulsions
- Dizziness/fainting
- Double/blurred vision
- Stroke
- Tremor/shakiness

Psychiatric

- Anxiety
- Depression
- Moodiness
- Suicide attempt
- Mental illness
- Nervousness

Endocrine

- Cold intolerance
- Heat intolerance
- Change in appetite/thirst
- Diabetes
- Thyroid disease/Goiter

Hematologic

- Bruise easily
- Anemia
- Thrombophlebitis/ Blood clots
- Cancer _____ (type)

Allergy/Immunologic

- Food allergy
- Bee allergy
- Severe allergic response/Anaphylaxis

