Name: _____

# NEW PATIENT COMPREHENSIVE EXAMINATION FORM

Chief Concerns:_____

_____

List ongoing Medical illnesses below (such as diabetes, hypertension):

1._____ 4._____

2._____ 5._____

3._____ 6._____

List any medications that have caused an **allergic reaction** (rash, shortness of breath, or shock) _____ _____ _____

List medications that you do not **tolerate**: _____ _____
_____ _____

**Date of Immunizations**:

Pneumovax: _____ Prevnar: _____ Tetanus: _____

Hepatitis A vaccine:_____ Hepatitis B vaccine: _____

Tuberculosis (PPD) test:_____ Influenza: _____

Other vaccines:_____

## Family History

| | Alive/Age | Health Problems | Deceased/Age | Cause of Death |
|---|---|---|---|---|
| Father | _____ | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ | _____ |
| Brothers | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| Sisters | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| Sons | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| Daughters | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |

Name: _____

## PERSONAL HISTORY

(Please circle or answer below where appropriate)

Marital Status: Single Married Divorced Widowed
Occupation: _____
Living Will: Yes No
Tobacco: None
Currently smoke_____packs/day and have done so for_____years
Previously smoked_____packs/day for_____years stopped in_____
Use chewing tobacco: Yes No

Alcohol: None
Liquor: number of ounces per day_____
Beer: number of cans/bottles/day_____
Wine: number of glasses/day_____

Substance Abuse: None currently abuse previously abused
What substance? _____

Caffeine(coffee, tea, caffeinated soda): None Number of 8oz servings a day_____

Exercise: Type_____ amount per week_____

Diet: No specific diet, diabetic, weight reduction, low saturated fat, low salt

**CURRENT MEDICATIONS**
**Please Bring All Medications With You (In The Bottles) And List All Of The Information Below:**

| Med. Name/Strength | How Med. Taken | Number of Refills |
|---|---|---|
| 1._____ | 1. _____ | 1. _____ |
| 2._____ | 2. _____ | 2. _____ |
| 3._____ | 3. _____ | 3. _____ |
| 4._____ | 4. _____ | 4._____ |
| 5._____ | 5. _____ | 5. _____ |
| 6._____ | 6. _____ | 6. _____ |
| 7._____ | 7. _____ | 7. _____ |

**Preferred Pharmacy:**
Local:_____

Mail Order:_____

Name: _____

List Surgeries, major hospitalizations, accidents (with dates):

1._____ 3._____

2._____ 4._____

Date of last complete physical exam: _____

Date of last cholesterol blood test: _____ Result (if known) _____

Date of last eye exam:_____ Eye Doctor: _____

Have you had your stool checked for blood? Yes No When_____
Flexible Sigmoidoscopy Yes No When_____
Barium Enema Yes No When_____
Colonoscopy Yes No When_____

Date of last EKG: _____ Date of last Chest x-ray:_____

Any other heart (cardiac) studies: _____

**PHQ-2**

| Over the past 2 weeks, how often have you been bothered by any of the following problems? | Not At all | Several Days | More Than Half the Days | Nearly Every Day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |

**For Women only**:

Date/Result of last gynecological exam (breast and pelvic):_____

Name of Gynecologist: _____

Date of last menstrual period:_____ Date of last pap smear_____

Have you had previous abnormal pap smears? _____

Date/Result of last mammogram:_____

Date/Result of last bone density scan:_____

**For Men only**:

Date of last prostate exam:_____

Date of last PSA:_____ Result (if known) _____

Name: _____

1. GENERAL: Change in activity and energy, appetite change, weight change, fever, chills, night sweats

2. HEAD: Headache, trauma

3. EYES: Visual changes, double vision

4. EARS: Ringing, hearing loss, infection, drainage, pain

5. NOSE/THROAT: Nose bleed, gum bleeding, tongue soreness, difficulty swallowing, hoarseness

6. LUNGS: Shortness of breath, cough, wheezing, coughing up blood

7. HEART: Chest pain, heart skips, rapid heart rate, exertional shortness of breath

8. ABDOMEN: Stomach pain, sour taste in throat, nausea, vomiting, diarrhea, constipation, black stools, blood in stool

9. URINARY: ***Men***: Difficulty in urination, blood in urine, prostate enlargement, sexual problems, penile discharge

   ***Women***: Painful urination, increase in frequency of urination, blood in urine, vaginal discharge, vaginal bleeding outside of normal menstrual cycle, menopause, vaginal dryness, hot flashes, mood swings

10. JOINTS/MUSCLES: Pain in joints, pain in muscles, weakness joint swelling, Backache

11. NEUROLOGICAL: Dizziness, loss of consciousness, transient loss of function in arms and legs, seizures

12. SKIN: Rashes, non-healing lesions, history of skin cancer

13. BREAST/CHEST: Breast lumps or tenderness, chest wall tenderness

14. EMOTIONAL: Nervousness, mood swings, depression, difficulty coping

15. ENDOCRINE: Thyroid trouble, heat or cold intolerance, diabetes, excessive thirst, hunger or urination

16. BLOOD/GLANDS: Anemia, easy bruising, easy bleeding, swollen glands

EXPLANATIONS: _____

_____