Adult Medicine Specialists, PA

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Basic History and Physical Questionnaire
PLEASE PRINT!!

Date:_____ Phone #:_____

Name:_____ SS#:_____ DOB:_____

Address:_____

Thank you for taking the time to answer these questions before seeing the doctor or provider. Having a complete history will assist the provider in thoroughly evaluating your health status. Please answer questions as completely as possible. The assistant who calls you to the exam room can help you with any questions you may have. The doctor or provider will review this with you when you are seen.

Specialist:

Please list any other physicians you see for care. (Name and City)

_____ _____

_____ _____

Current Medication:

(Please include vitamins and all over the counter medications or supplements.)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Past Medical History: Do You Have?

(When appropriate include approximate year.)

Diabetes_____ Heart Disease_____If so, have you had a heart attack?_____

Have you had a heart catherization?_____ Heart rhythm problem?_____

High Blood Pressure_____ Heart Failure_____ Arthritis_____

Immune Disorder (lupus, scleroderma, etc.)_____ Stroke_____

Cancer_____ Leukemia_____

Stomach Ulcers_____ Hiatal Hernia_____Thyroid Disease_____

Kidney Stones_____ Emphysema_____ Chronic Bronchitis_____

Other_____

Past Surgical History:
(Operations—Please include approximate dates.)

_____ _____

_____ _____

_____ _____

Risk Factors:
Smoking (packs/day)_____

If you have quit smoking include when you stopped and how many years smoked._____

Alcohol use (drinks/day)_____ Drug use_____

Caffeine (drinks/day)_____ Exercise (times/week)_____

High Risk Behavior (ex. Promiscuity)_____

Family History:
(Include things like heart disease, diabetes, high blood pressure, and cancer. Also, indicate age at death if indicated and cause of death.)
Father:_____

Mother:_____

Brothers:_____ _____

Sisters:_____ _____

Social History:
Marital Status:_____ Education:_____

Place of Residence:_____

Able to care for self:_____ Occupation:_____

Children (# and ages):_____

Health problems of children:_____

_____

Recent Travel:_____

Review of Systems:
(Please check off beside any recent problems in these areas)
Skin:

_____rashes _____lumps _____sores _____lesions _____color change
Family History of:_____

Head, Eyes, Ears, Nose, Throat:

_____headache _____migraines _____visual disturbances _____eye pain
_____ringing in ears _____ear pain _____nasal congestion
_____nosebleeds _____frequent colds _____dental problems
_____hoarseness _____sore throat _____runny nose _____sinus trouble
_____other_____
Family History of:_____

Neck:

_____lumps _____swollen glands _____pain _____stiffness
Family History of:_____

Respiratory:

_____coughing _____wheezing _____shortness of breath with vigorous exercise
_____coughing up blood _____excessive phlegm production
Family History of:_____

Breasts:

_____nipple discharge _____lumps _____tenderness
Family History of:_____

Cardiac:

_____chest pain ____heart fluttering ____sit on side of the bed at night to catch breath
_____inability to sleep flat _____chest pain with exercise
Family History of:_____

Extremities:

_____leg swelling _____leg cramps, pain in legs with exercise
_____varicose veins _____blood clots in legs
Family History of:_____

Stomach:

_____difficulty swallowing _____reflux _____sour taste in mouth _____diarrhea
_____constipation _____rectal bleeding _____blood in stool _____hemorrhoids
Family History of:_____

Urinary:

_____blood in urine _____frequency _____urgency _____burning on urination
_____menstrual irregularity _____vaginal discharge/frequency
_____sexual/erectile problems _____frequent urinary infections
_____last monthly period_____menopause_____
Family History of:_____

Blood Disorders:

_____easy or excessive bruising _____history of blood transfusions _____anemia
_____bleeding disorders
Family History of:_____

Immunity/Infection:

_____swollen glands _____chills _____sweats _____fevers _____HIV high risk behaviors
_____history of pelvic inflammatory disease
Family History of:_____

Endocrine:

_____frequent urination _____frequent thirst _____excessive hunger
_____significant weight (lbs) change in past few months:_____
_____heat or cold intolerance
Family History of:_____

Neurological:

_____passing out spells _____seizures _____paralysis _____numbness
_____headaches _____swimmy head _____lightheadedness _____memory loss
Family History of:_____

Musculoskeletal:

_____joint swelling _____joint stiffness _____joint pain
Family History of:_____

Psychiatric:

_____depression _____anxiety _____unusual stress _____difficulty sleeping
Family History of:_____

Obstetric History:

pregnancies_____ # live births_____
miscarriages_____ # abortions_____
Complications in pregnancy_____
_____

Preventive Care Review:

(Approximate date)
Physical Examination_____ Tetanus Vaccine_____ Flu Shot_____
Pneumovax (pneumonia vaccine)_____ Hepatitis B (vaccine)_____
Prostate Screen_____ Hemoccult Screen (Blood in stool)_____
Flexible Sigmoidoscopy (Scope in rectum)_____
Colonoscopy:_____ EGD:_____
Mammogram_____ Pap Smear_____ Cholesterol Check_____
Dental Visit_____
Last TB Test_____ Was is positive?_____
MMR_____
Eye exam _____