



PHYSICAL EXAM HEALTH HISTORY

Santa Rosa Sports & Family Medicine

Name: _____

DOB: _____ Age: _____

Please check off if you have had any problems with or are presently experiencing any of the following:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Unexplained weight loss/gain | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> T.B. | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Chest pain/tightness | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Abdominal discomfort | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Colitis | <input type="checkbox"/> Hepatitis or jaundice | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Nausea | <input type="checkbox"/> Head or neck radiation | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Venereal Diseases | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Impotence or Erectile dysfunction |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Seizures | |

If you checked any of the above, please give additional information here: _____

Please list and supply the dates of:

Operations: _____

Hospitalizations other than for surgery: _____

Immunization history – have you had:

Tetanus or Tdap Y/N _____ When? _____ Pneumovax Y/N _____ When? _____

Hepatitis B Y/N _____ When? _____ Seasonal Flu Y/N _____ When? _____

When did you have your last:

Pap Smear? _____ Breast Exam? _____ Mammogram? _____

Prostate Exam? _____ Colonoscopy? _____ Cholesterol Check? _____

(please continue to second page)

Family History: Has any member of your family (parents, grandparents, siblings) ever had the following?

Cancer (type?) _____ Which family member? _____ Age at diagnosis: _____

High blood pressure _____ Which family member? _____ Age at diagnosis: _____

Heart disease _____ Which family member? _____ Age at diagnosis: _____

Diabetes _____ Which family member? _____ Age at diagnosis: _____

Strokes _____ Which family member? _____ Age at diagnosis: _____

Mental illness _____ Which family member? _____ Age at diagnosis: _____

Drug or alcohol addiction _____ Which family member? _____ Age at diagnosis: _____

Glaucoma _____ Which family member? _____ Age at diagnosis: _____

Bleeding diseases _____ Which family member? _____ Age at diagnosis: _____

Other: _____

Medications – (Please include prescription, over-the-counter, vitamins, herbs, etc) _____

Drug Allergies: No known allergies Allergies: please list medicine name and type of reaction:

Prevention: Do you smoke? Yes No If yes, how many packs a day? _____

Do you want to quit? Yes No Would you like information on smoking cessation? Yes No

Are you on birth control? Yes No If yes, method: _____

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

Do you drink caffeine? Yes No If yes, how many drinks per day? _____

Do you use recreational drugs? Yes No If yes, explain: _____

Have you worked with chemicals, paints, asbestos, or other hazardous materials? If yes, explain:

Do you exercise regularly? Yes No If yes, type, duration and number of times/week: _____

Do you have a 'living will'? Yes No If yes, please provide a copy.

Do you wish to be tested for AIDS? Yes No

This information is for use by your health professional in your confidential medical record.