PHYSICAL EXAM HEALTH HISTORY

Santa Rosa Sports and Family Medicine

Name: _____

DOB: _____ Age: _____ Date: _____

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

❑ High Blood Pressure	❑ Cancer	❑ Change in Bowel Habits	❑ Colitis
❑ Problems with Urination	❑ Bloody Stool	❑ Constipation/Diarrhea	❑ Hemorrhoids
❑ Lower Back Problems	❑ Pneumonia	❑ Persistent Cough	❑ Seasonal Allergies
❑ COPD/Emphysema	❑ Bronchitis	❑ Unexplained Weight Loss/Gain	❑ Tuberculosis
❑ Shortness of Breath	❑ Asthma	❑ Gallbladder Disease	❑ Blood Disorders
❑ Chest Pain/Tightness	❑ Headache	❑ Abdominal Discomfort	❑ Skin Diseases
❑ Alcohol/Drug Abuse	❑ Fatigue	❑ Hepatitis or Jaundice	❑ Depression
❑ Swollen Ankles	❑ Indigestion	❑ Immune System Disorders	❑ Anemia
❑ Diabetes	❑ Seizures	❑ Nausea/Vomiting	❑ Heart Disease
❑ Head or Neck X Ray	❑ Arthritis	❑ Sexually Transmitted Diseases	❑ Thyroid Disease
❑ Rheumatic Fever	❑ Gout	❑ Kidney Disease/Kidney Stones	❑ Lightheadedness
❑ High Cholesterol	❑ Ulcers	❑ Impotence/Erectile Dysfunction	❑ Other_____

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

_____

Please list and supply the dates of:

Operations/Surgeries: _____

_____

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? _____

Medications – Please include prescriptions, over-the-counter, vitamins, herbs, etc. _____

_____

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

_____

_____

(please continue to back side)

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 (Type?) _____ Which Family Member? _____ Age at diagnosis: _____

Strokes _____ Which Family Member? _____ Age at diagnosis: _____

Mental Illness (Type?) _____ 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 (Type?) _____ Which Family Member? _____ Age at diagnosis: _____

Other: _____ Which Family Member? _____ Age at diagnosis: _____

When did you have your last:

Pap Smear? _____ Mammogram? _____ Breast Exam? _____

Prostate Exam? _____ Colonoscopy? _____ Cholesterol Check? _____

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?

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, please explain: _____

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

_____

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

_____

Have you completed an Advanced Healthcare Directive? Yes No
If yes, please provide a copy for our files.

If not, are you interested in information on this? Yes No

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