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 ☐Yes ☐No When? _____ Pneumovax ☐Yes ☐No When? _____

Hepatitis B ☐Yes ☐No When? _____ Seasonal Flu ☐Yes ☐No 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 on next 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 (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? ☐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, 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.