

NEW PROVIDENCE INTERNAL MEDICINE ASSOCIATES

COMPREHENSIVE EVALUATION

Name _____

Age _____

Doctor _____

Date of Physical _____

Please fill in the following:

(If additional space is needed, feel free to use the margins or an additional sheet)

1. Chronic health problems: _____

2. Other significant health problems in the past: _____

3. Operations: _____

4. Hospitalizations for a non-surgical problem: _____

5. Medications (prescription, non-prescription, vitamins, herbal, supplements, etc.)

Name	Strength	Doses per Day

6. Allergies or serious reactions to any medications or other substances (e.g. food, latex, contact, etc): _____

7. Family history:

	age	age at death	cause of death	other serious health problems
Father				
Mother				
siblings				

8. Do you smoke cigarettes, pipe, or cigar? Yes No ;Have you smoked in the past? Yes No;
If yes, how much and for how many years? _____ packs per day for _____ years. When did you quit? _____

9. How many drinks of alcoholic beverages do you have per week? (One drink is equal to: 2 oz. of hard liquor, 4 oz. of wine, or 12 oz. of beer) _____

10. What type of work do you do? _____

11. How many hours a week do you work at your job? _____

12. Any dangerous exposures at work (e.g. asbestos, chemical solvents, etc)? _____

13. What is your marital status? _____

14. How many children do you have? _____

15. Do you wear seatbelts when driving or as a passenger in a car? _____

16. Do you get any regular aerobic exercise(e.g. walk, jog, bicycle)? Please specify what type and how often. _____

17. Do you now take any recreational drugs regularly (e.g. marijuana, cocaine, etc.)? _____

18. Have you ever taken recreational drugs intravenously? _____

19. How do you feel your health is? _____

20. Names of other doctors who you see _____

21. Do you have a living will? _____

22. Are you on a special diet (e.g. vegetarian, etc.)? _____

REVIEW OF SYMPTOMS

(Please circle any symptom that is recent, frequent, or otherwise significant to you)

General

Fatigue; Lethargy; Generalized Weakness; Poor sleep: How many hours do you sleep at night: _____ ?; Do you stop breathing during sleep? ; Unintentional weight loss; Fever; Swollen glands

Heart/Circulation

Any chest symptom such as pain, pressure, tightness or burning (especially with any exertion); Palpitation or abnormal sensation of the heart beating; Pain in the legs with walking; Swelling of the ankles

Breathing/Lungs

Shortness of breath or labored breathing with exertion, at rest, or laying down; Persistent cough; Cough productive of blood or mucous; Wheezing

Stomach/Digestion

Loss of appetite; Heartburn; Indigestion; Nausea; Vomiting; Vomiting up blood; Diarrhea; Constipation; Blood in the stool; Black stools; Hemorrhoids; Pain in the abdomen

Upper Respiratory

Ear pain or pressure; Deafness; Sinus pain, pressure or discharge; Diminished sense of smell; Sore throat; Swallowing that is difficult or painful; Sneezing

Eyes

Poor vision; Painful eyes; Discharge from eyes; Cataracts; When was your last visit to the ophthalmologist (eye doctor)? _____

Skin

Any rash; New spots or sores on skin; Any skin cancers removed in the past; Scalp problem; Jaundice (yellowing of skin); Do you use sunblock? _____

Urinary

Urination that is painful, too frequent; Bloody or abnormally colored urine; Any previous kidney stones; Unintentional leakage of urine; How many times do you wake up at night to urinate? _____

Men only: any loss of power of the urinary stream; Feeling of incompletely emptying the bladder

Sexual

Are you heterosexual, homosexual, or bisexual? Have you recently had multiple sexual partners? _____; Diminished or absent sexual drive?

Men only: Difficulty getting or maintaining erections; Lumps or pain in the testicles; Discharge coming out of the penis; Type of birth control used: _____

Women only: Abnormal vaginal dryness; Painful sexual intercourse; Vaginal discharge; Type of birth control used: _____

Gynecological (women only)

How many times have you been pregnant? ____ ; How many times have you delivered children? ____; How many miscarriages or abortions? ____; How often do you get your period? ____; Are your periods regular? ____; Do you ever have bleeding in between your periods? ____; Symptoms before or during your period (cramps, mood changes, bloating); How old were you when you stopped having your periods? (menopause) ____; Any hot flashes? Bleeding long after completed menopause; Date of last Pap test: ____; Date of last mammogram: ____; Do you do breast self exam? ____

Skeletal

Any joint painful or swollen; Back pain; Pain going down the arm or leg; Previous serious broken bones

Neurologic

Black out or faint; Weakness on one side of the body or face, even if lasted only a short time; Lightheaded, dizzy, or spinning of the room; Tremor (shaking of hands); Problem with coordination; Headaches

Emotional

Feelings of being depressed, blue, sad, anxious, nervous, irritable; Ever been under the care of a psychiatrist, psychologist, or therapist?

Have you ever been physically or emotionally abused by someone close to you?

Are there any cultural, religious or other issues that we should know about in order to better care for you?

Any other medical or health issues that you would like to discuss with the doctor:

To be completed by doctor or nurse on the day of the physical:

- Hemocults, colonoscopy
- Mammogram, Pap test, Dexa scan
- Calcium, vitamins
- Immunizations: Tetanus, Influenza, Pneumococcal, Hep B
- Routine use of aspirin
- Next visit or check-up