

# NEW PROVIDENCE INTERNAL MEDICINE ASSOCIATES

## COMPREHENSIVE EVALUATION

Name \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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: \_\_\_\_\_

Name: \_\_\_\_\_

date of birth: \_\_\_\_\_

**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; Memory loss

**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:

\_\_\_\_\_

hemocults	Annually after age 40		Pneumococcal	Once after age 65
colonoscopy	Every 5-10 years after age 45-50		Shingles/Zostavax	Once after age 60
mammogram	Annually after age 40		calcium	1000-1500 mg per day
Bone density (DEXA)	After menopausal		Vitamin D	400-800 units a day
Pap test	Annually after age 21		multivitamin	Daily after age 60
Tetanus/adacel	Every 10 years		Aspirin 81 mg a day	If cardiac risk
influenza	Annually			

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date of birth: \_\_\_\_\_