MONTGOMERY INTERNAL MEDICINE GROUP/ATLANTIC MEDICAL GROUP

PHYSICAL EXAMINATION

DATE: _____

NAME: _____ AGE: ____ DATE OF BIRTH:_____ PHONE: _____

Are there any health-related issues or problems that you wish to discuss? _____

_____

PAST MEDICAL HISTORY (check any that apply. Use the bottom of this for if necessary)

☐Asthma ☐Cancer (type) _____ ☐Liver disease (type) _____ ☐Sugar diabetes ☐Migraine ☐Seizure
☐Allergy ☐Heart Disease (type) _____ ☐Kidney disease (type) _____ ☐Diverticulosis ☐Cataracts ☐Ulcer
☐Arthritis ☐Elevated cholesterol _____ ☐Thyroid disease (type) _____ ☐High blood pressure ☐Gout ☐Stroke

OTHER: _____

PAST SURGICAL HISTORY (Check any that apply. May use the bottom of this form if necessary)

☐Appendectomy ☐Hernia ☐Cataract ☐Back ☐Joint Replacement (type)_____ ☐Biopsy (type)____
☐Gallbladder ☐ Hemorrhoid ☐Tonsils ☐Neck ☐Hysterectomy (partial or complete) ☐ Breast Skin

_____

ALLERGIES ☐ None Known ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Other: _____

REACTIONS _____

CURRENT MEDICATIONS (Include frequently used over the counter medications, vitamins, supplements, and herbal products.)

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY
1.			5.		
2.			6.		
3.			7.		
4.			8.		

FAMILY HISTORY (Check any that apply.) May use the bottom of this form if necessary)

RELATION	AGE	ALIVE (A) DEAD (D)	HIGH BLOOD PRESSURE	DIABETES	HEART DISEASE	CANCER (TYPE)	OTHER
FATHER							
MOTHER							
BROTHER							
SISTER							
CHILD							

PERSONAL HISTORY (Check any that apply. May use the bottom of this form if necessary)

☐Married Occupation _____ ☐Smoking DIET ☐ Eat Regular Meals ☐ Low Salt EXERCISE
☐Single _____ ☐Alcohol #drinks/week ☐Low Fat Eats Fast foods ___ times /month ☐N ☐ Y
☐Divorced ☐Sexually active ☐Drugs ☐Eats 5 Serving fruits/vegetables /day. Type _____
☐Widowed ☐Monogamous ☐Caffeine ☐Vegetarian ☐ Special diet _____ _____
☐Separated ☐STD ☐ Calcium supplements How much? _____ ___Times per wk
___ Minutes

GYNECOLOGIC HISTORY (Check any that apply.) May use the bottom of this form if necessary)

Age at 1st Period ___ Number of Children __ Last Period ____ Last Mammogram ___ Menses ☐Regular ☐Irregular
Age of Menopause ___ Number of Pregnancies __ Last Pap ___ Birth Control Method (If any) ___ ☐Self Breast exam? ☐PMS

REVIEW OF SYSTEMS (CHECK ANY THAT APPLY. May use the bottom of this form if necessary)

E.N.T.	CVS	RESP	CNS	GI	GU	SKIN
☐Sinusitis	☐Chest pain	☐Cough	☐Headache	☐Weight loss/gain	☐Frequency	☐Rash
☐TMJ	☐Chest pressure	☐Short of Breath	☐Dizzy	☐Abdominal Pain	☐Infections	☐Itch
☐Dizziness	☐Palpitations	☐Wheezing	☐Tremors	☐Blood in stool	☐Urgency	☐Dry
☐Congestion	☐Racing Heart	☐Phlegm	☐Seizures	☐Change in appetite	☐Discharge	☐Changing moles
☐Voice change	☐Murmurs	☐TB exposure	☐Paralysis	☐Diarrhea	☐Sexual dysfunction	☐Nails/hair problems
☐Hearing loss	☐Shortness of Breath	☐	☐Numbness	☐Constipation	☐Bleeding	Other _____
☐Legally Blind	Other _____	Other _____	☐Weakness	Other _____	Other _____	_____
☐Years since last eye exam ____	_____	_____	Other _____	_____	_____	
			_____			

IMMUNIZATIONS				
☐DT _____	☐PNEUMOVAX ____	☐ Influenza _____	☐ Hepatitis B	Hepatitis A ____
☐MMR	☐POLIO	☐ Lyme	Other : _____	