MONTGOMERY INTERNAL MEDICINE 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 ☐Allergy ☐Arthritis

☐Cancer (type) _____ ☐Heart Disease (type) _____ ☐Elevated cholesterol _____

☐Liver disease (type) _____ ☐Kidney disease (type) _____ ☐Thyroid disease (type) _____

☐Sugar diabetes ☐Diverticulosis ☐High blood pressure

☐Migraine ☐Cataracts ☐Gout

☐Seizure ☐Ulcer ☐Stroke

OTHER: _____

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

☐Appendectomy ☐Gallbladder ☐Hernia ☐ Hemorrhoid ☐Cataract ☐Tonsils ☐Back ☐Neck ☐Joint Replacement (type) _____ ☐Hysterectomy (partial or complete) ☐Biopsy (type) ____ ☐ 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 ☐Single ☐Divorced ☐Widowed ☐Separated

Occupation _____

☐Sexually active ☐Monogamous ☐STD

☐Smoking ☐Alcohol #drinks/week ☐Drugs ☐Caffeine

DIET ☐ Eat Regular Meals ☐ Low Salt ☐Low Fat Eats Fast foods ___ times /month ☐Eats 5 Serving fruits/vegetables /day. ☐Vegetarian ☐ Special diet _____ ☐ Calcium supplements How much? _____

EXERCISE ☐N ☐ Y Type _____ ___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.
☐Sinusitis ☐TMJ ☐Dizziness ☐Congestion ☐Voice change ☐Hearing loss ☐Legally Blind ☐Years since last eye exam _____

CVS
☐Chest pain ☐Chest pressure ☐Palpitations ☐Racing Heart ☐Murmurs ☐Shortness of Breath Other _____

RESP
☐Cough ☐Short of Breath ☐Wheezing ☐Phlegm ☐TB exposure ☐ Other _____

CNS
☐Headache ☐Dizzy ☐Tremors ☐Seizures ☐Paralysis ☐Numbness ☐Weakness Other _____

GI
☐Weight loss/gain ☐Abdominal Pain ☐Blood in stool ☐Change in appetite ☐Diarrhea ☐Constipation Other _____

GU
☐Frequency ☐Infections ☐Urgency ☐Discharge ☐Sexual dysfunction ☐Bleeding Other _____

SKIN
☐Rash ☐Itch ☐Dry ☐Changing moles ☐Nails/hair problems Other _____

IMMUNIZATIONS
☐DT _____ ☐MMR

☐PNEUMOVAX ___ ☐POLIO

☐ Influenza _____ ☐ Lyme

☐ Hepatitis B Other : _____

Hepatitis A ____