INTERNIST ASSOCIATES OF CENTRAL NEW YORK, PC

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PRE-EXAMINATION INFORMATION

NAME: ____ DATE OF EXAM: __________________
FIRST M LAST

DATE OF BIRTH: ______________________________________ BIRTHPLACE: ____________________

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Co-Habitant

Employer ____ Phone ______________________________________

What is the reason for your visit today? How are you feeling? ____

____

____

Do you have: DNR ___________________________ Health Care Proxy _________________ Living Will _________________________

FAMILY HISTORY

	Age	Living/Deceased Health Status	If Deceased, age at death	Cause
Father				
Mother				
Brother/Sister				
Husband/Wife				
Children				

Have any blood relatives had (Check) ❑ High Blood Pressure ❑ Stroke ❑ High Cholesterol ❑ Heart Disease
❑ Diabetes ❑ Osteoporosis ❑ Arthritis ❑ Tuberculosis
❑ Mental Illness ❑ Lung Disease ❑ Cancer

PAST HISTORY ❑ No change since last visit

Have you ever had? (Please Check): ❑ High Blood Pressure ❑ High Cholesterol ❑ Heart Disease ❑ Pneumonia
❑ Mitral Valve Prolapse ❑ Asthma ❑ Lung Disease ❑ Tuberculosis ❑ Diabetes
❑ Cancer ❑ Ulcers/Reflux ❑ Hepatitis ❑ Chicken Pox ❑ HIV
❑ Blood Transfusion ❑ Other ____

PAST HISTORY

Have you had any operations? ❑ **No change since last visit**

Type	Year	Hospital	Surgeon

Have you been a patient in a hospital for any other reason? ❑ **None since last physical**

Reason	Year	Hospital	Physician

Have you had any serious injuries? ____

____

Please list present medication with dosage and how taken. (bring in all medicines to your appointment.)

____

____

____

____

Do you use non-prescription medicines, diet supplements, vitamins, calcium, iron? ____________________

____

____

Do you have any allergies to medication? ____

____

Did you ever smoke? ______________ How much? ______________ What? ______________ How Long? ______________

Do you drink alcohol? ______________ What and how much? ______________________________

Have you ever used illegal substances? ❑Yes ❑ No

Have you had immunizations?

MMR 1 ___________ Year ___________ MMR ___________ Pneumovax ___________ Year ___________

Tetanus ___________ Year ___________ Hepatitis ___________ Year ________ Hepatitis ___________ Year ________

Have you had any of the following?

Chest x-ray ___________ CT scan _____________ MRI ____________ Barium Enema ____________ GI Series ____________

Tuberculin Skin Testing ____________________ Stress Test _____________________ Sigmoid/Colonoscopy ______________________

List other doctors you see: ____

____

What is your weight? ____________ Height? ____________ Has it changed in the last 6 months? Gain ________ Lost? ________

Do you sleep well? _____________ How many hours ________________ Do you regularly exercise? ________________

Have you ever been employed in an area that exposed you to hazardous infections or substances? _______________________________

Explain ____

Do you follow any special diet? ____

Amount of coffee, tea, cola daily ____

Amount of salt ❑ Large ❑ Medium ❑ Small

FOR MEN AND WOMEN: Are you sexually active? ❑ Yes ❑ No

Sexual orientation:
- ❑ Heterosexual
- ❑ Homosexual
- ❑ Bisexual

FOR WOMEN ONLY:

Name of OB/GYN Physician ____

Date of last pap smear ____

Date of last mammography ____

Date of last bone density ____

Date of last breast examination ___________________________________ Do you do self exams __________________________

Menstrual History:
Age at onset ___________________ Length of cycle (between periods) ___________________ Days of flow ________________

❑ Heavy ❑ Medium ❑ Light

Are they regular? ____________________ Pain or cramps ____________________ Date of last period ____________________

Vaginal discharge ____

Pregnancies:
How many pregnancies? ____

How many miscarriages? ____

Any stillbirths? ____

Cesarean sections? _____________ Any complications? ____

FOR MEN ONLY:
Date of last PSA? ____

Date of last rectal exam? ____

Do you perform regular testicular exams? ____

SYMPTOMS

Have you had or do you have (please check):

EYES ❑
- ❑ Blurred or Double Vision
- ❑ Glaucoma
- ❑ Cataracts
- ❑ See floating spots
- ❑ Wear glasses, contact lenses
- ❑ Macular Degeneration

EARS/NOSE/THROAT ❑
- ❑ Deafness / Hearing aids
- ❑ Earaches
- ❑ Ringing in ears
- ❑ Frequent colds/hoarseness/ sore throat
- ❑ Nose bleeds
- ❑ Swollen glands
- ❑ Runny nose, post nasal drip
- ❑ Phlegm/sputum
- ❑ False teeth
- ❑ Bleeding from teeth or gums
- ❑ Difficulty chewing
- ❑ Sores on your tongue

CHEST ❑
- ❑ Asthma
- ❑ Persistent cough
- ❑ Cough up blood
- ❑ Wheezing
- ❑ Lung disease
- ❑ Snoring
- ❑ Sleep apnea
- ❑ Shortness of breath
- ❑ Pain/Pressure/discomfort in chest
- ❑ Palpitations/irregular beats
- ❑ Heart trouble
- ❑ High blood pressure
- ❑ Dizziness/fainting
- ❑ Blood clots in lungs or legs
- ❑ Swelling in ankles
- ❑ Discomfort in legs when walking or at rest

ABDOMEN ❑
- ❑ Indigestion / Heartburn
- ❑ Nausea/vomiting
- ❑ Hiatal hernia
- ❑ Ulcers
- ❑ Gallbladder problems
- ❑ Loss of appetite
- ❑ Intolerance of certain foods
- ❑ Abdominal pain
- ❑ Pulse sensation
- ❑ Change in bowel habits
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bloody/black bowel movements
- ❑ Pain in rectum
- ❑ Hemorrhoids (piles)

LYMPH NODES ❑
- ❑ Swelling

URINARY TRACT ❑
- ❑ Kidney or bladder trouble
- ❑ Discomfort passing urine
- ❑ The urge to urinate at night
- ❑ Loss of urine when coughing or sneezing
- ❑ Trouble making a stream
- ❑ Reoccurring urinary tract infection
- ❑ Kidney stones
- ❑ Difficulty with sexual ability
- ❑ Venereal disease

MUSCLES/NERVES ❑
- ❑ Difficult to walk or stand
- ❑ Broken bones
- ❑ Arthritis
- ❑ Bursitis
- ❑ Pain/Swelling in joints
- ❑ Muscle weakness
- ❑ Back pain/problems
- ❑ Headaches, frequent/severe
- ❑ Migraine headaches
- ❑ Convulsions / seizures
- ❑ Paralysis
- ❑ Tremor

Pain/numbness/tingling:
- ❑ Fingers/toes
- ❑ Around mouth

SKIN ❑
- ❑ Easily bruising
- ❑ Sores that won't heal
- ❑ Rashes
- ❑ Acne

ENDOCRINE ❑
- ❑ Ability to tan easily
- ❑ Feel warmer or colder the rest of family
- ❑ Anemia
- ❑ See floating spots
- ❑ Thyroid disease
- ❑ Diabetes

MENTAL STATUS ❑
- ❑ Difficult with memory
- ❑ Depression / Suicidal thoughts
- ❑ Anxiety ❑ Irritability ❑ Feeling of panic

CONSTITUTIONAL:
- ❑ Energy level
- ❑ Stamina
- ❑ Fatigue
- ❑ Fever / chills

REVIEWED BY: **DATE**

provider signature/initial