TRUCKEE TAHOE MEDICAL GROUP

Comprehensive Exam

Age ____ Birthdate: ___________________

Patient to complete first two pages

Best Phone #: ___________________

Past Medical History

❑ No known drug allergies Allergies:____

Past Medical/Psych Problems (diagnosis & date)

____
____
____
____
____

Surgeries (give date) ____________________________
____
____
____

Medications (include supplements & vitamins)

Name Dose Times of Day Since When

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________
7. ______________________________________
8. ______________________________________
9. ______________________________________

Further Medical History *(please check if you have had any of the following:)*

- ☐ Stroke
- ☐ Epilepsy
- ☐ Migraines
- ☐ Depression/Anxiety
- ☐ Glaucoma
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Asthma
- ☐ Emphysema, COPD
- ☐ Sleep Apnea
- ☐ TB (Tuberculosis)
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Ulcers
- ☐ Esoph Reflux
- ☐ Diverticulitis
- ☐ Pancreatitis
- ☐ Hepatitis
- ☐ Gallstones
- ☐ Hemorrhoids
- ☐ Kidney Stones

- ☐ Cancer ______________
- ☐ Skin Disorders/Cancers
- ☐ Arthritis
- ☐ Gout
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Blood transfusions
- ☐ Anemia
- ☐ Alcoholism
- ☐ Drug Dependency
- ☐ Chlamydia/Gonorrhea
- ☐ Genital Herpes
- ☐ HIV

WOMEN:

No. of Pregnancies: _______

No. of Deliveries: ________

☐ Ever had abnormal Pap smear? Age ____

Last Menstrual Period Date: _________ (or Menopause?)

Using contraception now? _______________________

Habits:

Do you Smoke or Chew Tobacco?

☐ Yes: How many?_____ Since when? ____________

☐ I quit _____ years ago. I smoked for _____ years.

☐ I have never smoked.

How often do you drink Alcohol? How much per day or week?

____

____

Do you use other recreational drugs? If so, what type:

____

Immunizations:

(Note year received)

___Tetanus / Pertussis

___Flu

___Pneumovax

___ Hep B ___Hep A

___Measles, Mumps,Rubella

___Chicken Pox (or had disease?_____)

___Zoster (Shingles)

With whom do you live? (please give names, ages, relationship)

____

Type of work / Occupation? ____________________________

What are your exercise habits? Type, Duration, Times per week

____

What are your eating habits? Note # of servings Fruit/Veggies

Breakfast_________ Lunch _________ Dinner____________ _

Have you traveled recently? Where? ______________________

Screening Tests: (note Year done, if applicable)

_____ Colonoscopy

_____ Mammogram

_____ Pap smear / pelvic exam

_____ PSA / prostate exam

_____ DEXA scan (osteoporosis)

______ Cholesterol test

Name ___________________________________

Date____________________

Over for notes. Reviewed: ______

Family History:

Does anyone in your family have (or has anyone had) the following diseases? Please write how you are related and approximate age of diagnosis.

- ☐ Heart attacks, stents or bypass surgery at young age (men<55, women<65) ______________________
- ☐ Stroke ______________________
- ☐ Hypertension ______________________
- ☐ High cholesterol ______________________
- ☐ Diabetes ______________________
- ☐ Autoimmune or rheumatic diseases ______________________
- ☐ Cancers (esp. colon, breast, thyroid, ovarian, uterine, prostate, testicular) What type? ______________________
- ☐ Depression, anxiety or addictions ______________________
- ☐ Death at a young age (cause?) ______________________
- ☐ Osteoporosis ______________________
- ☐ Other ______________________

Review of Systems

Place a check in the box if you have any of the following symptoms.

General
- ☐ Sleep problems
- ☐ Change in appetite
- ☐ Chills
- ☐ Fatigue
- ☐ Night sweats
- ☐ Change in weight
- ☐ Fever
- ☐ Bone pain / ache

Skin
- ☐ Mole size/color change
- ☐ Itching
- ☐ Rashes
- ☐ Bruising / bleeding

Neurologic
- ☐ Headache
- ☐ Dizziness / vertigo
- ☐ Fainting
- ☐ Numbness
- ☐ Weakness
- ☐ Tremor
- ☐ Seizure
- ☐ Memory loss
- ☐ Problems concentrating
- ☐ Off-balance

Head and Neck
- ☐ Vision changes
- ☐ Hearing difficulty / changes
- ☐ Taste changes
- ☐ Nose congestion
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Sore throat
- ☐ Eye pain
- ☐ Hoarseness / voice change
- ☐ Mouth dryness
- ☐ Swelling in neck
- ☐ Neck pain

Endocrine
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Sensitive to heat/cold
- ☐ Nipple discharge
- ☐ Breast lumps
- ☐ Testicle lumps
- ☐ Hair/skin changes

Cardiovascular
- ☐ Chest pain/tightness
- ☐ Short of breath with exertion
- ☐ Ache in arms with exertion
- ☐ Short of breath at night
- ☐ Sleep with extra pillows
- ☐ Irregular heart beat
- ☐ Fast heart beat
- ☐ Swelling in legs
- ☐ Leg cramps with walking

Respiratory
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Bloody sputum
- ☐ Pain with breathing

Gastrointestinal
- ☐ Abdominal pain
- ☐ Indigestion / reflux
- ☐ Trouble swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Black, tar-like stools
- ☐ Change in stool
- ☐ Loss of bowel control

Genitourinary
- ☐ Blood in urine
- ☐ Pain/burning with urination
- ☐ Frequent urination
- ☐ Hard to start & stop urinating
- ☐ Loss of bladder control/incontinence
- ☐ Pain during intercourse

Men:
- ☐ Discharge from penis
- ☐ Difficulty with erections

Women:
- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Painful cramping
- ☐ Irregular periods

Musculoskeletal
- ☐ Joint Pain
- ☐ Swelling or redness
- ☐ Back pain
- ☐ Muscle aches
- ☐ Discolored fingers/toes
- ☐ Recent injuries

Psychological
- ☐ Feeling depressed
- ☐ Anxious
- ☐ Mood swings
- ☐ Thoughts of harming yourself or others
- ☐ Obsession with weight
- ☐ Binge eating

Reviewed: ______

Name ______________________

Date ______________________