



PHYSICAL EXAM HEALTH HISTORY

Santa Rosa Sports and Family Medicine

Name: _____

DOB: _____ Age: _____ Date: _____

Please check if you have had any problems with or are presently experiencing any of the following:

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Problems with Urination | <input type="checkbox"/> Bloody Stool | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Unexplained Weight Loss/Gain | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Blood Disorders |
| <input type="checkbox"/> Chest Pain/Tightness | <input type="checkbox"/> Headache | <input type="checkbox"/> Abdominal Discomfort | <input type="checkbox"/> Skin Diseases |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Immune System Disorders | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Head or Neck X Ray | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disease/Kidney Stones | <input type="checkbox"/> Lightheadedness |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Impotence/Erectile Dysfunction | <input type="checkbox"/> Other _____ |

If you checked any of the above, please give additional information here: _____

Please list and supply the dates of:

Operations/Surgeries: _____

Hospitalizations other than for surgery: _____

Immunization History – have you had:

Tetanus or Tdap Y/N _____ When? _____ Pneumovax Y/N _____ When? _____

Hepatitis B Y/N _____ When? _____ Seasonal Flu Y/N _____ When? _____

Medications – Please include prescriptions, over-the-counter, vitamins, herbs, etc. _____

Drug Allergies: No known allergies Allergies – please list medicine name and type of reaction.

