**REDROCK MEDICAL GROUP**
**INITIAL HISTORY AND PHYSICAL**

NAME: _____ BIRTH DATE: _____ AGE: _____

SEX: M F OCCUPATION: _____ RACE: _____

WHO REFERRED YOU TO OUR OFFICE? _____

WHAT IS YOUR MAIN COMPLAINT? _____

HOW LONG HAS THIS BEEN A PROBLEM? _____

IS THIS RELATED TO WORK OR A CAR ACCIDENT? YES NO

IF YES EXPLAIN: _____

WHAT MEDICATIONS HAVE YOU TAKEN FOR THE ABOVE PROBLEM?

_____

WHAT TESTS HAVE YOU HAD CONCERNING THIS? _____

_____

PLEASE LIST ANY MEDICATION YOU ARE ALLERGIC TO: _____

_____

PLEASE CHECK ANY SURGERIES YOU HAVE HADA NMD LIST DATE OF SURGERIES:

**LIST ALL CURRENT MEDS:**

BRAIN_____ _____

CATARACT_____ _____

LUNG_____ _____

DEFIBRILATION_____ _____

HEART BYPASS OR HEART VALVE____ _____

ULCER_____ _____

COLON____ _____

ARTERIAL BYPASS IN LEGS_____

OTHER_____

PLEASE LIST PAST HOSPITALIZATIONS:

DATE: _____ REASON: _____ HOSP: _____ MD: _____

DATE: _____ REASON: _____ HOSP: _____ MD: _____

DATE: _____ REASON: _____ HOSP: _____ MD: _____

PLEASE LIST PAST INJURIES OR ACCIDENTS:

DATE: _____INJURY: _____ DATE: _____INJURY: _____

PLEASE CIRCLE: YES OR NO 

DO YOU HAVE A HISTORY OF:

ASTHMA . . . . . YES NO

ARTHRITIS . . . . . YES NO

BRONCHITIS . . . . . YES NO

COPD . . . . . YES NO

DIABETES . . . . . YES NO

EMPHYSEMA . . . . . YES NO

HIGH BLOOD PRESSURE . . . . . YES NO

HEART ATTACK . . . . . YES NO

CHEST PAIN (ANGINA) . . . . . YES NO

GLAUCOMA . . . . . YES NO

THYRIOD PROBLEMS . . . . . YES NO

ULCERS . . . . . YES NO

HIATAL HERNIA . . . . . YES NO

COLON POLYPS . . . . . YES NO

HIGH CHOLESTEROL LEVEL... . . . . YES NO

CANCER . . . . . YES NO

BLOOD TRANSFUSION . . . . . YES NO

CHICKEN POX . . . . . YES NO

MEASELS . . . . . YES NO

POLIO . . . . . YES NO

SCARLETY FEVER . . . . . YES NO

FAMILY HISTORY:

FATHER'S AGE:____ ALIVE OR DECEASED, HEALTH PROBLEMS_____

MOTHER'S AGE:____ ALIVE OR DECEASED, HEALTH PROBLEMS_____

BROTHERS OR SISTERS: PLEASE LIST AGES AND ANY HEALTH PROBLEMS

CHILDREN PLEASE LIST AGES AND ANY PROBLEMS_____

SPOUSE'S AGE ____ALIVE OR DECEASED, HEALTH PROBLEMS _____

HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ANY OF THE FOLLOWING ILLNESSES? PLEASE CIRCLE ALL THAT APPLY.

| | | | |
|---|---|---|---|
| ARTHRITIS | DIABETES | MIGRAINES | ALLERGIES |
| BLEEDING DISORDER | RHEUMATIC FEVER | BREAST CANCER | COLON CANCER |
| KIDNEY PROBLEMS | EPILEPSY | HIGH BLOOD PRESSURE | PEPTIC ULCER |

SOCIAL AND ENVIROMENTAL HISTORY

HIGHEST LEVEL OF EDUCATION _____ MILITARY EXPERIENCE YES NO
PRESENT JOB_____ YEARS THERE _____

HAVE YOU EVER BEEN EXPOSED TO ASBESTOS AT WORK YES NO
IF YES, PLEASE EXPLAIN _____

DO YOU SMOKE? YES NO IF NOT, DID YOU EVER SMOKE? YES NO
IF YES PLEASE LIST AVERAGE # OF CIGARETTES SMOKES PER DAY_____
DO YOU DRINK COFFEE? YES NO IF YES, HOW OFTEN _____
DO YOU DRINK ALCOHOL? YES OR NO IF YES, HOW OFTEN _____

PREVENTIVE HEALTH MEASITRES

LAST CHEST XRAY RESULTS _____ REASON_____
TB SKIN TEST YES NO IF YES, WERE RESULTS NEGATIVE OR POSITIVE,
CIRCLE ONE

FOR WOMEN: DATE OF LAST MAMMOGRAM_____ RESULTS_____
PAP SMEAR_____ RESULTS_____
AGE AT FIRST MENSTRAL CYCLE_____ NUMBER OF LIVE BIRTHS_____
NUMBER OF PREGNANCIES_____ NUMBER OF MISCARRIAGES

DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS? PLEASE CIRCLE ALL THAT APPLY.

EXCESSIVE BLEEDIG SPOTTING DISCHARGE ITCHING VENEREAL DISEASES
FRO MEN: DATE OF LAST PSA TEST RESULTS_____

DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS? PLEASE CIRCLE ALL THAT APPLY.

PAIN SWELLING LUMPS DISCHARGE POTENCY PROBLEMS VENEREAL DISEASE

## SYSTEM REVIEW

PLEASE CIRCLE ANY OF THE FOLLOWING PROBLEMS YOU RAVE HAD

| | |
|---|---|
| GENERAL: | Fatigue, weight loss or gain, fever, chills or sweats |
| SKIN: | Rash, itching, sores, hives, changes in moles |
| HEAD & NECK: | Headaches, trauma, pain, stiffness |
| EYES: | Wear glasses, double vision, itchiness, dryness, redness |
| EARS: | Hearing loss, buzzing, dizziness, pain |
| NOSE: | Dryness, bleeding, discharge, blockage, decreased or altered smell, sneezing |
| BREASTS: | Discharge or bleeding, lumps, infection |
| RESPIRATORY: | Cough, sputum or phlegm production, shortness of breath, blood in sputum, blue nails |
| HEART: | Chest pain, trouble breathing while lying down, breathing difficulties after falling asleep, palpitations, any exercise limitations |
| VASCULAR: | Pain in the legs with exertion, ulcers, phlebitis |
| STOMACH & COLON: | Altered appetite, trouble swallowing, nausea, vomiting, black or tarry stools abdominal pain, diarrhea, hernia, constipation, hemorrhoids, excess gas |
| KIDNEY & URINARY: | Difficulty urinating, pain when urination, blood in urine, trouble with bladder control, urinating frequency especially at night, kidney stones |
| BONES, JOINTS & MUSCLES: | Joint pain, tenderness, weakness, sprains, swelling, stiffness, backache |
| ENDOCRINE & METABOLIC: | Diabetes, temperature intolerance, increase in thirst, change in hair, loss of hair |
| NERVOUS SYSTEM: | Dizziness, stroke, tremors, altered memory, altered strength, seizures, problems with coordination |

**YOUR SLEEPING HABITS**

**PLEASE CHECK ALL THAT APPLY TO YOU**

_____Sleeping during the day or sleep attacks?

_____Naps during the day?

_____Memory or concentration problems?

_____Trouble getting to sleep at night?

_____Awaken during the night? If so, how many times?_____

_____Awaken too early in the morning?

_____Wake up tired and unrested in the morning?

_____Do you snore? If so, estimate how loud:_____

_____Are you irritable or depressed?

_____Use sleeping pills to help you sleep?

_____Has anyone told you that you stop breathing at night?

_____Do you jerk or kick your legs while you sleep?

_____Go to bed and get up at different times on weekends compared to during the week? Any other comments or question, please use space below:

_____

_____

_____

_____

_____

_____