Preventative Examination History Form

Name: ________________________________ Date: _____________

Have you had a significant or prolonged problem with any of the following?

Check Yes or No; if in doubt, leave blank.

General:

Feeling tired: [Y] [N]

Feeling poorly: [Y] [N]

Feelings of weakness: [Y] [N]

Recent change in weight: [Y] [N] Increase or Decrease?

Persistent fever: [Y] [N]

Temperature intolerance: [Y] [N]

Eyes:

Wearing (please chose one): Glasses / Contacts

Eye injury or disease: [Y] [N]

Pain in or around the eyes: [Y] [N]

Eye allergies: [Y] [N]

Red eyes: [Y] [N]

Overflow of tears: [Y] [N]

Seeing double: [Y] [N]

Blurry Vision: [Y] [N]

When was your last eye exam: ____________________

Ears:

Loss of hearing: [Y] [N] Right / Left / Both Ears

Deafness: [Y] [N]

Ringing in the ears: [Y] [N] Right / Left / Both Ears

Popping noise in the ears: [Y] [N] Right / Left / Both Ears

Discharge from the ears: [Y] [N] Right / Left / Both Ears

Ears feel full: [Y] [N] Right / Left / Both Ears

Nose and Sinus:

Allergies or Hay fever: [Y] [N]

Nasal Drainage: [Y] [N]

Nasal Stuffiness: [Y] [N]

Nosebleeds: [Y] [N] How frequent____________

Mouth and Throat:

Mouth sores: [Y] [N]

Soreness or pain of tongue: [Y] [N]

Bleeding gums: [Y] [N]

Teeth symptoms (pain or loss of teeth): [Y] [N]

Drip or drainage down the throat from above: [Y] [N]

Sore throat: [Y] [N]

Pain in the jaw: [Y] [N]

Soreness or pain of mouth: [Y] [N]

Nervous System:

Headaches: [Y] [N] Frequency: _______________

Fainting: [Y] [N]

Limb weakness: [Y] [N]

Numbness: [Y] [N] Location: __________________

Tingling: [Y] [N] Location:______________________

Depression: [Y] [N]

Memory lapses or loss: [Y] [N]

Feeling nervous: [Y] [N]

Anxiety: [Y] [N]

Dizziness: [Y] [N]

Cardiac:

Chest pain or discomfort: [Y] [N]

Palpitations: [Y] [N]

Leg pain with exercise: [Y] [N]

Swelling in both ankles: [Y] [N]

Soft tissue swelling in both feet: [Y] [N]

Difficulty breathing during exertion (movement): [Y] [N]

Difficulty breathing when lying down: [Y] [N]

Respiratory:

Chronic cough: [Y] [N]

Coughing up blood: [Y] [N]

Wheezing: [Y] [N]

Coughing up sputum: [Y] [N]

Digestive:

Increased or decreased appetite: [Y] [N] Which?_______________

Difficulty swallowing: [Y] [N]

Abdominal pain: [Y] [N]

Yellowing of the skin or eyes: [Y] [N]

Nausea: [Y] [N]

Vomiting: [Y] [N] Frequency: _______________

Vomiting blood: [Y] [N]

Change in bowel movement frequency: [Y] [N]

Constipation: [Y] [N] Frequency: _______________

Constipation self-treated with laxative: [Y] [N] Frequency:_______

Diarrhea: [Y] [N] Frequency: _______________

Change in stool Size/ Color _________________________

Red blood in bowel movement: [Y] [N]

Black or tarry stools: [Y] [N]

Flatus (gas): [Y] [N]

Heartburn: [Y] [N]

Regurgitation: [Y] [N]

Regurgitation with acid/burning taste: [Y] [N]

Genitourinary:

Blood in urine: [Y] [N]

Burning sensation during urination: [Y] [N]

Delays in starting urination (hesitancy): [Y] [N]

Urinary frequency during the day was _____________ times.

Urinary frequency during the night was ____________ times.

Urine content abnormal: [Y] [N] Describe: _________________

Pain during urination (dysuria): [Y] [N]

Painful inability to urinate: [Y] [N]

Passage or stones or gravel in the urine: [Y] [N]

Musculoskeletal:

Muscle aches; [Y] [N]

Diffuse joint pains (arthralgia's): [Y] [N]

Back pain: [Y] [N] Upper / Mid / Lower

Specific joint pains: [Y] [N] ______________________

Joint swelling : [Y] [N]

Joint stiffness: [Y] [N]

Endocrine:

History of Thyroid Disease: [Y] [N]

Taking medication for Diabetes: [Y] [N]

History of Cholesterol problems: [Y] [N]

Skin:

Skin lump: [Y] [N] Location: ________________

Rash: [Y] [N]

Skin sore: [Y] [N] Location: _________________

Itching; [Y] [N]

Dry skin: [Y] [N]

Change in mole: [Y] [N] Size / Shape / Color

Hair symptoms (loss): [Y] [N]

Abnormalities of the Toe Nails: [Y] [N] _____________

Abnormalities of the Finger Nails: [Y] [N] _____________

Male Genitourinary:

Penile Pain: [Y] [N]

Testicular Pain: [Y] [N]

Urinary stream is smaller: [Y] [N]

Urinary stream starts and stops: [Y] [N]

Groin swelling or pain: [Y] [N]

Inadequacy of penile erection: [Y] [N]

Sexual complaints: [Y] [N]

Please give to nursing staff when completed.

Thank you.

Female Genitourinary:

Vaginal pain: [Y] [N]

Vaginal discharge: [Y] [N]

Vaginal dryness: [Y] [N]

Vaginal odor: [Y] [N]

Pelvic Pain: [Y] [N]

Pain during intercourse: [Y] [N]

Abnormal periods: [Y] [N] Explain: -

____

Sexual complaints: [Y] [N]

Breast pain: [Y] [N] Right / Left / Both

Breast lump: [Y] [N] Right / Left / Both

Nipple Discharge: [Y] [N]

Please include dates for any procedures or surgeries you have had:

Procedures / Tests:

Colonoscopy: [Y] [N] ______________

Bone Density Studies (DEXA scan): [Y] [N] ________

Mammogram: [Y] [N] _____________

Cervical PAP Smear: [Y] [N] _____________

Abnormal PAP Smear: [Y] [N] ____________

Mastectomy:

Simple Mastectomy Left Breast ________________

Simple Mastectomy Right Breast ________________

Radical Mastectomy Left Breast ________________

Radical Mastectomy Right Breast ________________

Radical Mastectomy Bilateral ___________________

Hysterectomy:

Vaginal Hysterectomy: [Y] [N] _________________

Total Abdominal Hysterectomy: [Y] [N] __________

Ovaries Present: [Y] [N] Right / Left / Both