NORTH PHOENIX INTERNAL MEDICINE
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Patient Complete Physical Exam Form

Patient Name _____

Date of Birth _____ Age _____

You have been scheduled for Complete Physical Exam with Dr. Brubaker on _____.

NO FOOD OR DRINKS AFTER MIDNIGHT the night before your Physical Exam. You may drink WATER to keep you hydrated for the labs and take your REGULAR MEDICATIONS

Please answer these questions to the best of your ability and bring this form with you on your appointment date. Any questions that are not clear will be discussed at greater length at the time of your appointment.

Chief Complaints: (Please list the things that concerns you the most)

1. _____
2. _____
3. _____
4. _____

Allergies:

Are you allergic to ANY Medications_____

_____

Hayfever, Asthma, Eczema? _____

Others:_____

Family History:

Mother: Living or Deceased (Age) _____ Status of Health_____

Cause of Death _____

Father: Living or Deceased (Age) _____ Status of Health_____

Cause of Death_____

Brothers and/or Sisters_____

Are you Married? _____ Do you have Children?_____Number_____

Health?_____

Social History:

Do you smoke? _____ Have you ever smoked? _____

How much?_____Often? _____

Drink Tea or Coffee (Number of cups per day) _____

Alcohol? _____

Past History:

Surgeries: Date:

1. _____
2. _____
3. _____
4. _____

Any Medical Problems_____

_____

_____

Accidents/Fractures_____

_____

_____

Medications:

List of Medications you take and the dosage_____

_____

_____

_____

Review of Systems: (Do you have any History of...)

General:

Diabetes_____

Dizziness_____

Weight Changes_____

Head, Neck, Eyes: Vision_____Glasses/Contacts_____

Glaucoma_____Cataracts _____

Ears: Hearing _____ Ringing _____

Infections?_____

Nose: Polyps_____Bleeds _____

Hayfever_____ Sinusitis_____

Throat: Frequent Infection_____

Sores?_____ Tonsils_____

Neck: Masses _____Thyroid Problems _____

Goiter_____Pain?_____

Restricted Motion_____

Respiratory: Cough_____Coughing up Blood?_____

Any History of TB, Pneumonia, Asthma, Valley Fever, Bronchitis?_____

_____

CVS: History of Heart Disease_____

History of Hypertension_____

Chest Pain?_____ At Rest?_____ After Exercise?_____

Shortness of Breath? _____

Palpitations?_____

GI: How's your appetite?_____

Sticking of Food on Swallowing?_____

History of Ulcer_____Gallbladder Disease_____

Hiatus Hernia_____

Heartburn or Indigestion_____

Constipation_____Blood in Stool_____

Black Tarry Stools_____Hemorrhoids_____

Any Hernia_____

Appendectomy?_____

GU: *For Females:* Menstrual Cycle Regular?_____ Irregular?_____

Age At Menopause?_____ Number of Children_____

Bleeding after Menopause?_____

Hysterectomy_____

Breasts: Any Lumps?_____

Date of Last Mammogram_____Last Pap Smear_____

For Males: Any Prostate Problems?_____

Do you wake up at night to use the bathroom?_____

For Both: Burning on Urination?_____Blood in Urine?_____

Loss of Urine with Cough or Sneezing?_____

Back and Extremities: Any low Back pain?_____

Arthritis in ANY Joints?_____

Any Fractures?_____

Neurological: Any History of Seizures_____

Any History of Weakness, Paralysis, or Numbness_____

_____

Any Strokes_____

_____

Double Vision_____

Osteoporosis Risk Assessment:

First Degree Relative with Broken Hip, Wrist, or Back (Humpback)_____

_____

Do you have a thin Body Build?_____

Is your diet low in Calcium (less than 1500 mg/day with 1 glass of Milk=250mg)?__

_____

Do you get little Exposure to Sunlight?_____

Have you used Steroid Medication for more than 6 months?_____

_____

Do you get little Physical Activity (less than 2 times per week)?_____

_____

Any Eating Disorders (Previously or Current)?_____

_____

Menstrual Status:

Are you currently taking Hormones?_____

If Yes, for how long?_____

Living Will:

YES_____ NO_____

Do you consider having one?_____

Signature:_____

Date:_____