COMPREHENSIVE HISTORY QUESTIONNAIRE AND PHYSICAL EXAM

99204, 99214, 99215, 99244, 99245

Name _____ Today's Date _____

CURRENT MEDICAL PROBLEMS

Please list the medical problem for which you came to see the doctor. About when did they begin?

Problems	Date Began

Doctor's notes on chief complaint and present illness: _____

DOCTOR USE ONLY

FAMILY HISTORY	ALIVE & WELL	DECEASED	FOLLOW THE LINES ACROSS THE PAGE AND MARK THE APPROPRIATE BOX CAUSE OF DEATH (AGE)	HIGH BLOOD PRESSURE	HEART DISEASE	EPILEPSY	DIABETES	CANCER	ASTHMA	HAYFEVER	ARTHRITIS	KIDNEY DISEASE	GLAUCOMA	STROKE	MIGRAINE	MENTAL ILLNESS	ALCOHOLISM	BLEEDS EASILY	ANEMIA	PSORIASIS	ECZEMA
FATHER																					
MOTHER																					
BROS / SIS																					
BROS / SIS																					
BROS / SIS																					
BROS / SIS																					
MOTHER'S RELATIVES																					
FATHER'S RELATIVES																					

HOSPITAL ADMISSIONS	Indicate the year you were admitted to hospital and the reason. Do not include normal pregnancies.		
YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

MEDICATIONS	NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN
LIST ALL MEDICATIONS THAT YOU ARE NOW TAKING. INCLUDE OVER THE COUNTER Rx.						
				DRUG ALLERGIES		

REVIEW OF SYMPTOMS: Place a check mark in the appropriate blocks in the following lists of symptoms.

MD/Provider Notes

1. HEAD AND NECK

	Yes	No		Yes	No		Yes	No
Headaches	☐	☐	Ringing in ears	☐	☐	Chronic nose obstruction	☐	☐
Vision glasses	☐	☐	Pain in ears	☐	☐	Chronic sore tongue	☐	☐
Failing vision	☐	☐	Discharge from ear	☐	☐	Persistent sore gums	☐	☐
Eye pain	☐	☐	Repeated nosebleeds	☐	☐	Prolonged hoarseness	☐	☐
Double vision	☐	☐	Teeth problems	☐	☐	Persistent neck rigidity	☐	☐
See "floating lights"	☐	☐	Frequent colds	☐	☐	Swellings in neck	☐	☐
Severe hearing loss	☐	☐						

2. HEART — CARDIOVASCULAR

Heart Problems	☐	☐	Chest pain on effort	☐	☐	Ankles swell	☐	☐
Hypertension	☐	☐	Skipping/irregular heart beats	☐	☐	Difficult breathing	☐	☐

3. PULMONARY — LUNGS

Sit up to breathe easier	☐	☐	Spit up blood	☐	☐	Wheezing	☐	☐
Have chronic cough	☐	☐	Frequent chest colds	☐	☐	Have night sweats	☐	☐

4. STOMACH AND INTESTINES

Chronic abdominal pain	☐	☐	Vomit blood	☐	☐	Any blood from rectum	☐	☐
Persistent nausea	☐	☐	Skin turns yellow	☐	☐	Clay colored stools	☐	☐
Heartburn	☐	☐	Any chronic diarrhea	☐	☐	Habitual constipation	☐	☐
Appetite loss	☐	☐	Any black tarry stools	☐	☐	Have hemorrhoids	☐	☐

5. URINARY TRACT — ETC.

						OB GYN (For Women Only)		
Frequent urination	☐	☐	Pain with urination	☐	☐	Last menstrual period _____		
Hard to start urinary flow	☐	☐	Any leakage of urine	☐	☐	Painful menstruation	☐	☐
Scanty urination	☐	☐	Passed any stones	☐	☐	Excess menstruation	☐	☐
Any blood in urine	☐	☐	Any bedwetting	☐	☐	Bleed between periods	☐	☐
Frequent night urination	☐	☐	Any retention of urine	☐	☐	Any missed periods	☐	☐
						Number of pregnancies _____		
						Number of living children _____		

6. MUSCLES — JOINTS

Physically handicapped/limited	☐	☐	Any tingling sensations	☐	☐	Any paralysis	☐	☐
Joint or muscle problems	☐	☐	Any numbness	☐	☐	Any shaking	☐	☐
Shoulder pain	☐	☐	Disturbance in walking	☐	☐	Any strokes	☐	☐
Back pain	☐	☐	Any muscle jerking	☐	☐	Any seizures	☐	☐

7. NEUROLOPSYCHOLOGICAL

Depression	☐	☐	Paralysis/weakness	☐	☐	Psychotherapy/counseling	☐	☐
Nervous breakdown	☐	☐	Any memory loss	☐	☐	Any alcohol problem	☐	☐
Any mental problem	☐	☐	Personality changes	☐	☐	Any drug problem	☐	☐
Dizzy spells	☐	☐	Speech disturbances	☐	☐	Serious mental problem	☐	☐

8. SOCIAL HISTORY

Occupation _____

Smoking ..... ☐ ☐ ___ cigarettes ___ cigars ___ pipe Pks/day Yrs

Alcohol ..... ☐ ☐ ___ beer ___ liquor ___ wine

How much?_____ How often?

Street Drugs ..... ☐ ☐ Type _____

9. CURRENT WORK HISTORY

Where? _____

How long? _____ What type of work? _____

IF THERE ARE ANY ADDITIONAL HEALTH FACTORS IN YOUR HISTORY OR IF ANY OF THE ABOVE POINTS NEED CLARIFYING USE THIS SPACE FOR ADDITIONAL COMMENTS.