DiAGNOSTIC EVALUATION FORM (INTERNIST HISTORY AND PHYSICAL) DATE_____

❶

Name_____ Birthdate_____

Insurance Carrier_____

Referred by_____ Date_____

❷

History_____

_____

_____

_____

_____

❸

PH – Please list the following:

Surgery - _____

Injuries - _____

Hosps - _____

Drug Reactions - _____

Childhood diseases - _____

Illness – Please circle any of the following you have had:

Rheumatic fever - _____

Strep infection / scarlet fever - _____

Heart disease / high blood pressure - _____

Pneumonia / pleurisy / tuberculosis - _____

Asthma / hay fever - _____

Diabetes / jaundice / liver disease - _____

❹

SYSTEMS (Please circle any of the following you are having or have had trouble with and fill in spaces marked with*):

Weight

*Max_____

*Min_____

*Change_____

Head

Headache_____

Light-headed_____

Fainting (Synope)_____

Other_____

_____

Eyes

Glasses_____

Vis. Symp._____

Blurred Vision_____

Double Vision_____

Pain in Eyes_____

Other_____

_____

Genitourinary

Frequent urination_____

*Average number of time get up to urinate at night_____

Decrease in urinary stream_____

Incontinent_____

Bleeding in urine_____

Stone_____

Infect_____

Venereal Disease_____

Gynecologic

*Age at onset of menses_____

*Date or age of last menstrual period_____

*No. of pregnancies_____

*No. of miscarriages_____

Complication of pregnancies_____

Menses_____

Menopausal sympt_____

Ear, Nose, Throat

Hearing_____
Perforation_____
Dizziness_____
Ringing in Ears_____
Sinusitis_____
Tonsilitits_____
Hoarseness_____
Nosebleeds_____
Other_____

Teeth / Gums

Dentures_____
*Last Exam_____

Cardiorespiratory

Dyspnea (shortness of breath)_____
Orthopnea (shortness of breath lying down)_____
Noct. Dysp. (shortness of breath at night)_____
Chest pain_____
Palpitation_____
Murmur_____
Hi BP_____
Cough_____
Coughing blood_____
Sputum_____
Wheeze_____
Asthma_____
Other_____

Gastrointestinal

*Appetite_____
Nausea_____
Vomiting_____
Diarrhea_____
Constipation_____
Bleeding from intestine_____
Excessive gas_____
Change in bowel habit_____
History of ulcer_____
History of jaundice_____
History of colitis_____
Abdominal pain_____

Endocrine

Heat intolerance_____
Flushing_____
Skin disease or rashes_____
Nails_____
Thirst_____
Sugar in urine_____
Libido_____
Potency_____

Blood Disorders

Anemic_____
Blood disorder_____
Bleeding tendency_____
Abnormality of red cells_____
Abnormality of white cells_____
Abnormality of platelets_____

Musculoskeletal

Muscle Cramps_____
Pain_____
Swelling_____
Arthritis_____
Neck Pain_____
Back Pain_____
Injuries_____

Vascular

Pain_____
Edema_____
Varicosities_____
Thrombosis_____
Phlebitis_____

Allergies - Sensitivities

Rhinitis_____
Asthma_____
Skin_____
Reactions_____

Social

Habits_____
Work_____
Recreation_____
Travel_____
Alcohol_____
Tobacco_____

❺ FAMILY HISTORY

	Age	Alive Or Dead	Status of health or Cause of death
Father			
Mother			
Grandparent			
Brothers & Sisters			

Circle any of the following that are in members of your family (parents, siblings, grandparents, aunts, or uncles).

Tuberculosis_____
Heart Disease_____
High Blood Pressure_____
Diabetes_____
Gout/Arthritis_____
Cancer_____
Allergy_____
Psychiatric_____
Devel. abn._____
Other_____