Northeast Shoreline Internal Medicine
5 Durham Road, Building 3, Guilford, CT 06437

NORTHEAST MEDICAL GROUP
YALE NEW HAVEN HEALTH

Name:_____ **Date of Birth:**____/____/____ **Age:**_____ **Today's Date:**____/____/____

Comprehensive History and Physical Exam

Current Medical Problems

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

Chief complaint and history of present illness (completed by provider):

Current Medications

Please list all medications you are now taking, including those you buy without a prescription (such as aspirin, cold tablets, or vitamin supplements).
Please list name, dosage, and times per day.

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Allergies:

Immunizations:

Last Tetanus?_____ Pneumovax_____ Zostavax(Shingles)_____ Hepatitis B_____ Gardasil_____

Have you had the chicken pox? ☐ No ☐ Yes, at age _____, or received the Varicella Vaccine on _____.

Other:_____

Last Tuberculin (TB) skin test?_____ ☐ positive ☐ negative ☐ BCG Date_____ CXR ☐ No ☐ Yes, results_____

Social:

How many cigarettes do you smoke per day?_____ How many years have you smoked?_____

Are you ready to quit? ☐ Yes ☐ No. Any other drug use?_____

How much alcohol do you consume per day?_____ per week?_____ per month?_____

Diet_____

Exercise_____

What type of work/school do you do?_____

Who lives in the home with you?_____

Past Surgeries: ☐ None ☐ Yes (list by date with age)_____

Past illnesses including chronic conditions:_____

Hospitalizations:_____

Name:_____ **Date of Birth:**____/____/____ **Age:**_____ **Today's Date:**____/____/____

Family History If anyone in your family had the following, please check off the box.

☐ Cancer ☐ Tuberculosis ☐ Diabetes
☐ Strokes ☐ High Blood Pressure ☐ Heart Disease

Review of Systems: Please place a check mark in the appropriate box in the following list of symptoms.

Constitutional	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Have you had any weight loss?	☐	☐	Have you had any weight gain?	☐	☐	Fatigue?	☐	☐
What is your usual weight?	_____							
Head and Neck	**YES**	**NO**		**YES**	**NO**			
Headache	☐	☐	Vision/Glasses	☐	☐	_____		
Teeth problems	☐	☐	Allergy/Hay Fever	☐	☐	_____		
Eye problems	☐	☐	Swelling in the neck	☐	☐	_____		
Ear problems	☐	☐	_____			_____		
Heart-Cardiovascular	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Heart problems	☐	☐	Hypertension	☐	☐	Chest pain on effort	☐	☐
Ankles swell	☐	☐	Skipping/Palpitations	☐	☐	Heart Studies	☐	☐
_____			_____			*Date*: _____		
Pulmonary-Lungs	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Difficulty breathing	☐	☐	Chronic cough	☐	☐	Spit up blood	☐	☐
Frequent chest colds	☐	☐	Have night sweats	☐	☐	Wheezing	☐	☐
Stomach and Intestines	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Chronic abdominal pain	☐	☐	Vomit blood	☐	☐	Constipation/diarrhea	☐	☐
Persistent nausea	☐	☐	Liver problems	☐	☐	Any blood in bowel movement	☐	☐
Heartburn	☐	☐	Appetite loss	☐	☐	Any black tarry stools	☐	☐
						Hemorrhoids	☐	☐
Urinary Tract	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Frequent urination	☐	☐	Frequent urination at night	☐	☐	Impotence_____	☐	☐
Pain with urination	☐	☐	Any blood in urine	☐	☐	Sexually transmitted disease	☐	☐
Retention of urine	☐	☐	Passed any stones	☐	☐	_____		
OB/GYN (for women only)				**YES**	**NO**		**YES**	**NO**
Age menstruation started	_____		Any missed periods	☐	☐	Bleed between periods	☐	☐
Length of cycle _____days _____ weeks			Last menstrual cycle	_____		Sexually transmitted disease	☐	☐
Number of pregnancies _____			Number of living children	_____		_____		
Musculoskeletal	**YES**	**NO**		**YES**	**NO**			
Handicapped/limited	☐	☐	Joint/muscle problems	☐	☐	_____		
Any seizures	☐	☐	Tingling/numbness	☐	☐	_____		
Any paralysis	☐	☐	Back pain	☐	☐	_____		
Neuropsychological	**YES**	**NO**		**YES**	**NO**			
Depression	☐	☐	Alcohol/drug problems	☐	☐	_____		
Counseling/Therapy	☐	☐	Relationship problems	☐	☐	_____		