



NORTHSIDE URGENT CARE AND FAMILY MEDICINE

"Family Practice and Urgent Care till 8PM daily"

PHYSICAL EXAMINATION FORM

Name: _____

Current Medications (include Rx and over the counter)

Allergies: _____

If you currently have or have had in the past any of the following problems, **please mark** and explain below.

___ Disorder with eyes, ears, nose, throat

___ Stroke, epilepsy

___ Nervousness, Mental Problems

___ Thyroid, diabetes

___ Kidney stone, blood in urine

___ Cancer, tumor

___ Dizziness, fainting headache

___ Menstrual dysfunction

___ Asthma, shortness of breath

___ Back / joint aches, arthritis

___ Chest Pain / palpitations / heart murmurs

___ High blood pressure, heart problems

___ Hepatitis, pancreatitis, gall bladder

___ Stomach or abdominal ulcers

___ Prostate or venereal disease

___ Hemorrhoids, blood in stool, bowel irregularity

Explain _____

If there is any family history of the following conditions listed below, **please circle** the ones that apply to you.

Heart Disease, Diabetes, High Blood Pressure, Tuberculosis (TB), Cancer, Other

WOMEN ONLY Are you pregnant? Yes or No If yes, what is your due date _____

(Date of) Last menstrual cycle _____, Last pap smear _____, Last mammogram _____

Do you smoke? _____ Drink alcohol? _____ Use illegal drugs? _____ If yes, please explain what and How often _____

Operations / Hospitalizations: _____

Immunizations: Tetanus _____ Measles/MMR _____ Hepatitis _____ Pneumonia _____

Date of Last Medical Screening:

Cholesterol Check: _____

EKG: _____

Rectal Exam: _____

Blood sugar testing: _____

Colonoscopy: _____

Prostate Exam: _____

Stress Test: _____

Patient's Signature

Date

Physician's Signature

Date