New York Physical Medicine Center

Name:_____ Date:_____

PLEASE INDICATE IF YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING:

GENERAL
____Skin Rash
____Weakness/Lethargy
____Loss of Appetite
____Always Hungry
____Tend to be Hot or Cold
____Chills or Night Sweats
____Sleeping Difficulties

HEAD
____Frequent Headaches
____Dizzy Spells
____Fainting Spells

EYES
____Wear Glasses
____Eyesight Worsening
____Double Vision
____Eye Pains or Itching

EARS
____Deafness
____Earaches or Drainage
____Noise in Ears

NOSE
____Nasal Congestion/Sneezing
____Sinus Trouble/Hay Fever
____Nose Bleeds

LUNGS
____Wheezing/Coughing Spells
____Cough up Phlegm
____Shortness of Breath
____Emphysema
____Cough up Blood
____Exposed to TB

HEART
____Heart Racing/Palpitations
____High Blood Pressure
____Swollen Feet/Ankles
____Chest Pain
____Heart Attack
____Heart Murmur

GASTROINTESTINAL
____Heartburn or Indigestion
____Belching or Nausea
____Jaundice
____Difficulty Swallowing
____Stomach Pains
____Vomiting Blood
____Constipation
____Change in Bowel Habits
____Diarrhea
____Black or Bloody Stools
____Pain in Rectum
____Hemorrhoids
____Amoeba/Parasites

GENITOURINARY
____Frequent Urination
____Burning on Urination
____Pus or Blood in Urine
____Difficulty Starting Urine
____Dribbling with Cough etc.
____Other Kidney Disease
____Sex Difficulties

NEUROLOGIC
____Convulsions/Seizures
____Stroke/Paralysis
____Difficulty with Decisions
____Memory Problems
____Cry Often/Depressed
____Worry a Lot
____Considered Suicide
____Numbness or Tingling
____Weakness

MISCELLANEOUS
____Bleed/Bruise Easily
____Anemia/Low Blood
____Blood Disease
____Enlarged Glands/Nodes
____Aching Muscles/Joints
____Varicose Veins
____Leg Cramps/Pains
____Painful Feet
____Cancer
____Prolonged Fever

Past Medical History

PLEASE INDICATE WHICH OF THE FOLLOWING PROBLEMS YOU HAVE OR HAVE HAD:

____Asthma
___Tuberculosis
____Gallbladder Problems
____Venereal Disease
____Hepatitis
____Chronic Lung Disease
____Pancreas Problems
____Heart Trouble
____Kidney Stones
____Liver Problems
____Meningitis
____Pneumonia
____Diabetes
____ Rheumatic Fever
____Polio
____Ulcers

PLEASE LIST ALL OTHER MEDICAL PROBLEMS YOU HAVE OR ARE BEING TREATED FOR:

_____
_____
_____
_____

Past Surgical History

PLEASE INDICATE IF YOU HAVE HAD SURGERY ON ANY OF THE FOLLOWING:

____Head
____Stomach
____Intestines/Colon
____Mouth/Teeth
____Ears
____Larynx
____Prostate
____Heart
____Arm/Leg/Finger/Toe
____Broken Bones
____Brain
____Gallbladder
____Sinuses
____Rectum/Hemorrhoids
____Appendix
____Thyroid
____Ovaries
____Hernia
____Blood Vessels
____Kidney
____Cesarean Section
____Nose
____Eyes
____Tonsils
____Spleen
____Uterus
____Breast
____Lungs
____Liver
____Neck
____Back

PLEASE LIST ANY OTHER SURGERY YOU HAVE HAD:

_____
_____
_____
_____

FAMILY HISTORY

PLEASE INDICATE IF ANY FAMILY MEMBERS (Mother/Father/Siblings) HAVE HAD ANY OF THE FOLLOWING PROBLEMS. IF SO, WHO?

High Blood Pressure	YES	NO	_____
Heart Trouble	YES	NO	_____
Stroke	YES	NO	_____
Cancer	YES	NO	_____
Diabetes	YES	NO	_____
Ulcers	YES	NO	_____
Seizures	YES	NO	_____
Mental Illness	YES	NO	_____
Suicide	YES	NO	_____
Birth Defects	YES	NO	_____
Tuberculosis	YES	NO	_____
Hereditary Disease	YES	NO	_____