Northeast Georgia PHYSICIANS GROUP

MEDICAL HISTORY – Page 1

Name: _____ DOB: _____/_____/_____

Please take a few minutes to fill out our health history form. PLEASE fill in all areas, **on all pages**, BEFORE YOUR APPOINTMENT. Your answers will help the provider plan and provide your care.

Name: _____ Age: _____ Today's Date: _____/_____/_____

Weight: ____Height: ____ Family Members seen in the office: _____ Primary Care Provider: _____

Who referred you to the office: _____ Doctor/ Coach/Trainer / Family/Other_____
(circle)

Is this a work injury with a Workers Compensation Claim? ☐Yes ☐No Litigation pending? ☐Yes ☐No
Name of attorney (if applicable)_____ Phone #_____

Name of School: _____ Coach's name: _____☐Sport_____

What is the primary reason for this visit? *Please check (√)*

☐ **Toe** ☐ **Foot** ☐ **Heel** ☐ **Ankle** ☐ **Lower Leg** ☐ **Knee** ☐ **Thigh** ☐ **Hip** ☐ **Pelvis** ☐ **Back** ☐ **Neck**
☐ **Finger** ☐ **Hand** ☐ **Wrist** ☐ **Forearm** ☐ **Elbow** ☐ **Arm** ☐ **Shoulder** ☐ **Clavicle** ☐ **Ribs**
Other: _____ LEFT RIGHT BILATERAL (circle one)

☐ **Right** ☐**Left** ☐**Ambidextrous** **-Hand dominance**

Is this due to an injury? ☐Yes ☐No **Date of injury:** _____
If no date of injury, how long has it bothered you? _____
Describe where and how the problem occurred: _____
_____
_____

Have you had any diagnostic studies (xrays, MRI, ect.) done for this problem? ☐Yes ☐No If yes, please list_____
_____
Approx. Date:_____ Location performed:_____

How would you describe the pain? ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning Other_____
How often does the pain occur? ☐Constant ☐Intermittent ☐Recurring Other_____
Have you ever injured this area before? ☐Yes ☐No Does your pain keep you awake at night? ☐Yes ☐No
How severe is your pain? (**Rate on a scale from 0-10, 10 is worst)** _____

Do you have any of the following: ☐Swelling ☐Bruising ☐Tingling ☐Weakness ☐Redness ☐Numbness
Since my problem started, it is now: ☐ Better ☐Worse ☐ Unchanged
What makes your symptoms worse? ☐Standing ☐Walking ☐Lifting ☐Bending ☐Exercise ☐Twisting ☐Squatting
Kneeling Stairs Sitting Coughing/Sneezing Other_____
What makes your symptoms better? ☐Rest ☐Ice ☐Heat Other_____
Have you been treated for this condition? ☐Yes ☐ No If yes, treating physician/ER: _____
Describe the treatment: _____
_____
What medications have you taken for this problem?_____
Any relief from those medications? ☐Yes ☐No ☐ Partial relief ☐ Temporary relief ☐ How long?_____

Northeast Georgia PHYSICIANS GROUP

MEDICAL HISTORY - Page 2

Name: _____ DOB: _____/_____/_____

Comprehensive Review of Systems *Please check (√) a **YES** on each line and **if left blank it is assumed to be NO**.*

☐ **No Symptoms??(All answers below are NO.)**

CONSTITUTIONAL

Loss of appetite?	☐ Yes
Chills?	☐ Yes
Sweating Heavily at Night?	☐ Yes
Feeling Tired / Fatigue?	☐ Yes
Fever?	☐ Yes
Recent Weight Loss?	☐ Yes
Recent Weight Gain?	☐ Yes

HEAD, EAR, NOSE, THROAT

Ear Drainage?	☐ Yes
Hearing Loss?	☐ Yes
Nasal Congestion?	☐ Yes
Facial Pain?	☐ Yes
Ringing in Ears (Tinnitus)?	☐ Yes
Difficulty Swallowing	☐ Yes
Hoarseness?	☐ Yes

EYES

Sensitivity to Light?	☐ Yes
Worsening Vision/ Loss?	☐ Yes
Seeing Double (diplopia)?	☐ Yes

RESPIRATORY /CARDIAC

Cough?	☐ Yes
Difficulty breathing (dyspnea)?	☐ Yes
Wheezing?	☐ Yes
Chest Pain?	☐ Yes
Limb Swelling?	☐ Yes
Irregular heartbeat/Palpitations?	☐ Yes

GASTROINTESTINAL

Heartburn?	☐ Yes
Abdominal pain?	☐ Yes
Black tarry or blood in stools?	☐ Yes
Constipation?	☐ Yes
Diarrhea?	☐ Yes
Nausea?	☐ Yes
Vomiting?	☐ Yes
Yellow Skin / eyes (Jaundice)?	☐ Yes

METABOLIC/ENDOCRINE

Cold Intolerant?	☐ Yes
Heat Intolerant?	☐ Yes

GENITOURINARY

Painful urination?	☐ Yes
Frequent Urination?	☐ Yes
Blood in urine?	☐ Yes
Urge / or Urinary Incontinence?	☐ Yes

MUSCULOSKELETAL

Sudden Unexplained Fractures?	☐ Yes
Joint / or Bone Pain?	☐ Yes
Joint Swelling?	☐ Yes
Joint Stiffness	☐ Yes

SKIN

Cyanosis-Blue coloration of skin	☐ Yes
Rash?	☐ Yes
Itchy Skin?	☐ Yes

IMMUNOLOGICAL

Seasonal Allergy?	☐ Yes
Asthma?	☐ Yes

NEUROLOGICAL

Dizziness?	☐ Yes
Headache?	☐ Yes
Spinning Dizziness (Vertigo)	☐ Yes
Numbness / Tingling?	☐ Yes
Convulsions (Seizures)?	☐ Yes
Fainting (Syncope)?	☐ Yes
Involuntary Movement(Tremors)	☐ Yes
Muscle Weakness?	☐ Yes
Feeling Weak on exertion?	☐ Yes
Memory Loss?	☐ Yes
Poor Coordination?	☐ Yes

HEMATOLOGIC

Easy bleeding?	☐ Yes
Easy bruising?	☐ Yes

PSYCHIATRIC

Depression?	☐ Yes
Anxiety?	☐ Yes
Insomnia (Difficulty Sleeping)?	☐ Yes

List Any Other Symptoms:

Northeast Georgia PHYSICIANS GROUP

MEDICAL HISTORY - Page 3

Name: _____ DOB: _____/_____/_____

Medical Problems (List all past and current medical problems)

Arthritis	☐ No ☐ Yes	Osteoporosis	☐ No ☐ Yes	History MRSA or VRE	☐ No ☐ Yes
Cancer	☐ No ☐ Yes	Depression	☐ No ☐ Yes	Other medical problems:	_____
Coronary Artery Disease	☐ No ☐ Yes	Lung Problems	☐ No ☐ Yes		
Diabetes	☐ No ☐ Yes	High Cholesterol	☐ No ☐ Yes		
Heart Disease	☐ No ☐ Yes	Stomach Ulcers	☐ No ☐ Yes		
Hypertension	☐ No ☐ Yes	Sleep Apnea	☐ No ☐ Yes		
Kidney Disease	☐ No ☐ Yes	Pregnant or Nursing	☐ No ☐ Yes		

Surgical History *Please check (√) all that apply*

☐ Neurological Surgery	☐ Thyroid
☐ Hysterectomy	☐ Appendectomy
☐ Tonsillectomy	☐ Prostate
☐ Joint Replacement	☐ Hernia Repair
☐ Cardiac Surgery	☐ Gallbladder
☐ Breast Surgery	☐ Other:

Please describe any other major surgeries and previous hospitalizations:

_____
_____
_____
_____

CURRENT MEDICATIONS: *List all medications- list any additional on back of page*

Medicine	Over the Counter Vitamins/Supplements	Dosage	How often?	Provider
Ex: Lasix		**20mg**	**Twice a day**	**Dr. Jones**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Northeast Georgia PHYSICIANS GROUP

MEDICAL HISTORY - Page 4

Name: _____ DOB: _____/_____/_____

Preferred Pharmacy:_____

ALLERGIES: List all allergies *and the type of reaction* (Ex: Sulfa- rash, Codeine- nausea, etc.)

Allergies	Type of Reactions
1.	
2.	
3.	
4.	

FAMILY HISTORY: *Please check &/or list all family members that apply*

Illness	Relation to you
□ No known Problem	□ Mother □ Father □ Sibling □ Child □ Other: _____
□ Anesthesia Problem	□ Mother □ Father □ Sibling □ Child □ Other:
□ Broken Bones	□ Mother □ Father □ Sibling □ Child □ Other:
□ Cancer	□ Mother □ Father □ Sibling □ Child □ Other: _____
□ Clotting Disorder	□ Mother □ Father □ Sibling □ Child □ Other:
□ Collagen Disease	□ Mother □ Father □ Sibling □ Child □ Other:
□ Diabetes	□ Mother □ Father □ Sibling □ Child □ Other: _____
□ Osteoporosis	□ Mother □ Father □ Sibling □ Child □ Other:
□ Drug Abuse	□ Mother □ Father □ Sibling □ Child □ Other: _____

SOCIAL HISTORY: *Check &/or answer each question.*

Tobacco Use:	□ Current □ Former (Quit Year _____) □ Never □ Exposure to Smoke □ E-Cigs □ Other :
Alcohol Use:	□ Never drink □ Occasional/social drinker □ _____ # of drinks/day of alcohol
Drug Use:	□ None □ Other use:
Sexually Active:	☐ No ☐ Yes – with ☐Male ☐ Female □ Both # of _____ sexual partners
Employment:	Current Job/Occupation?
Marital Status:	□ Married □ Divorced □ Widowed □ Single # of Children? _____ # of Grandchildren?

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian: _____ Date: ____/_____/_____