Revere Health Cancer Center

DIAGNOSTIC EVALUATION FORM (INTERNIST HISTORY AND PHYSICAL)

Name:_____ Birth date:_____

Insurance carrier:_____

Reason for visit:_____

_____

_____

PAST HISTORY - Please list the following:

Surgery - _____

Injuries - _____

Hospitalizations - _____

Hormone therapy - _____

Drug reactions - _____

Childhood blood disorders or cancers - _____

Illness - Please select any of the following you have had -

Heart Disease ❑ High Blood Pressure ❑ Pneumonia ❑ Pleurisy ❑ Tuberculosis ❑

Asthma ❑ Hay Fever ❑ Diabetes ❑ Jaundice ❑ Liver Disease ❑

Any other illnesses: _____

Habits -	Alcohol	Tobacco	Recreational drug use	International Travel
	Current ❑	Current ❑	Current ❑	Yes ❑
	Past ❑	Past ❑	Past ❑	No ❑

SYSTEMS (Mark any of the following you **currently** have issues with. Fill in the correct amount/info for items with an *)

Weight

Weight change ❑

Head

Headache ❑ Light-headed ❑

Fainting (Syncope) ❑

Other _____

_____

Eyes

Vis. Symp ❑ Blurred vision ❑

Double vision ❑ Eye pain ❑

Other _____

_____

Genitourinary

Frequent urination ❑ Bleeding in urine ❑

Average number of times you get up to urinate each night:_____

Loss of bladder control ❑ Infection ❑

Decrease urinary stream ❑ Stone ❑

Venereal disease ❑

Gynecologic

*Age at onset of menstruation _____

*Date or age of last menstrual period_____

*No. of pregnancies_____No. of miscarriages_____

Complication of pregnancies ❑ Menopausal symp ❑

Ear, Nose, Throat

Hearing ❑ Perforation ❑ Dizziness ❑

Ringing in ears ❑ Sinusitis ❑ Tonsillitis ❑

Hoarseness ❑ Nosebleed ❑

Other _____

_____

Teeth / Gums

Dentures ❑

*Last exam _____

Cardiorespiratory

Dyspnea (shortness of breath) ❑

Orthopnea (shortness of breath lying down) ❑

Noct. Symp. (shortness of breath at night) ❑

Chest pain ❑ Palpitation ❑ Murmur ❑

Hi BP ❑ Cough ❑ Coughing blood ❑

Sputum ❑ Wheeze ❑ Asthma ❑

Other_____

_____

Gastrointestinal

*Appetite_____

Nausea ❑ Vomiting ❑ Diarrhea ❑ Excessive gas ❑

Constipation ❑ Intestinal bleeding ❑

Change in bowel habit ❑ History of ulcer ❑

History of Jaundice ❑ History of colitis ❑

Abdominal pain ❑

Endocrine

Heat Intolerance ❑ Flushing ❑ Rashes ❑

Skin disease ❑ 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

Heat Intolerance ❑ Flushing ❑ Rashes ❑

Skin disease ❑ Nails ❑ Thirst ❑

Allergies - Sensitivities

Rhinitis ❑ Asthma ❑ Skin ❑

Allergic reactions ❑ - If so, to what_____

Types of reactions_____

Social Support:

Live alone ❑ Married ❑

Occupation:_____

Retired ❑

FAMILY HISTORY

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

Mark any of the following conditions a family member has experienced (parents, siblings, grandparents, aunts, or uncles).

Tuberculosis ❑ Heart Disease ❑ Diabetes ❑

High Blood Pressure ❑ Gout/Arthritis ❑

Cancer ❑ Allergy ❑ Psychiatric ❑

Devel. abn. ❑

Other_____