CMB Health Specialties

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Comprehensive History

Today's Date ___/___/____

Patient Name: _____ Date of Birth:___/___/____ Sex: (circle) M F
Marital Status: (circle) Married Separated Widowed Single Occupation:_____

Questionnaire

Eyes

Past/Present	Yes	No	Comments and Notes
Do you wear glasses or contacts?			
Does your eyesight blur?			
Is your eyesight worse?			
Do you ever see double?			
Do you see colored halos around lights?			
Do you have pain or itching around your eyes?			
Do you have redness and discharge around your eyes?			
Do your eyes blink or water most of the time?			
Have you had any trouble with your eyes in the last few years?			

Ear, Nose, and Throat

Past/Present	Yes	No	Comments and Notes
Do you have difficulty hearing?			
Have you had earaches lately?			
Buzzing or other noises in your ears?			
Do you get motion sickness?			
Do you have problems with your teeth?			
Have any sore or swelling gums or jaw?			
Is your tongue sore?			
Have your senses changed lately?			
Is your nose stuffed up when you don't have a cold?			
Does your nose run when you don't have a cold?			
Do you ever have sneezing spells?			
Do you have head colds frequently?			
Do you have nosebleeds for no reason?			
Is your throat sore when you don't have a cold?			
Has your voice been hoarse when you didn't have a cold?			

Cardiovascular

Past/Present	Yes	No	Comments and Notes
Have you been told that you have high blood pressure?			
Do you get pains or tightness in your chest?			
Have you been bothered by a thumping or racing heart?			
Does every little effort leave you short of breath?			
Do you have dizziness or lightheadedness?			
Do you wake up at night short of breath?			
Do you use more pillows to help you breath at night?			
Do you have trouble with swollen feet or ankles?			
Do you get cramps in your legs at night, or when walking?			
Have you been told you have a heart murmur?			

Respiratory

Past/Present	Yes	No	Comments and Notes
Do you wheeze or gasp to breathe?			
Are you bothered by coughing spells?			
Do you cough up a lot of phlegm?			
Have you ever coughed up blood?			
Do you have colds more than once a month?			
Do you sweat, or have night sweats?			

Gastrointestinal

Past/Present	Yes	No	Comments and Notes
Are you troubled by heartburn?			
Do you feel bloated after eating?			
Are you troubled by belching?			
Do you suffer discomfort or pain in your stomach?			
Do you become nauseated after eating?			
Have you ever vomited blood?			
Is it difficult or painful to swallow?			
Are you constipated more than twice a month?			
Are your bowel movements loose for more than a day?			
Are your bowel movements ever black, or bloody?			
Are your bowel movements ever gray in color?			
Do you suffer with pain with bowel movements?			
Have you had any bleeding from your rectum?			

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Past/Present	Yes	No	Comments and Notes
Do you frequently get up at night to urinate?			
Do you urinate more than 5 or 6 times a day?			
Do you wet your pants or the bed?			
Have you ever had burning pain when you urinate?			
Has your urine ever been brown, black or bloody?			
Do you ever have difficulty in starting a urine flow?			
Do you have a constant feeling that you have to urinate?			

MEN ONLY	Yes	No	
Is your urine stream weak or slow?			
Has the doctor ever told you that you have prostrate trouble?			
Have you had any burning or discharge from your penis?			
Is there any swelling or lumps in your testicles?			
Do your testicles get painful?			
Are you experiencing any sexual difficulties?			

WOMEN ONLY	Yes	No	
What was the date of your last menstrual period? Date of your last Pap?	___/___/_____	___/___/_____ (pap)	
Was your last period normal?			
Are you past menopause, or had a hysterectomy?			
If yes, have you noticed any vaginal bleeding?			

DO YOU HAVE:	Yes	No	
Any heavy bleeding with your periods?			
Any bleeding between periods?			
Have bleeding after intercourse?			
Vaginal itching, dryness, or discharge?			
"Hot flashes"?			
Do you do a monthly self breast exam?			

LIST:

Number of pregnancies			
Living Children			
Premature Births			
Miscarriages			
Still Births			
Have you ever had an abortion?	Yes	No	

Musculoskeletal

Past/Present	Yes	No	Comments and Notes
Do you have stiff or painful muscles or joints?			Describe
Are your joints ever swollen?			
Do you have pains in the back or shoulders?			
Are your feet painful?			
Are you handicapped in any way?			Describe:

Neurological

Past/Present	Yes	No	Comments and Notes
Do you ever feel faint?			
Is any part of body numb?			Describe:
Have you ever had seizures or convulsions?			
Has your handwriting changed lately?			
Do you have a tendency to shake or tremble?			
Have you had/ having dizziness?			

Psychiatric

Past/Present	Yes	No	Comments and Notes
Do you find it hard to concentrate, remember, or make a decision?			
Do you feel lonely or depressed?			
Do you have a tendency to worry a lot?			
Do you cry often?			
Would you say you have a hopeless outlook?			
Do you have difficulty relaxing?			
Are you troubled by frightening dreams or thoughts?			
Do you have a tendency to be shy or sensitive?			
Do you have a strong dislike for criticism?			
Do you lose your temper often?			
Do little things annoy you?			
Are you disturbed by a work or family problem?			
Have you ever considered suicide?			
Have you ever desired or sought psychiatric help?			

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Endocrine

Past/Present	Yes	No	Comments and Notes
Recently have you lost/ gained weight?			
Do you feel too hot/cold?			
Have you lost interest in eating lately?			
Do you always seem hungry?			
Are you more thirsty than usual lately?			
Any swelling in your armpits or groin?			
Exhausted/ fatigued most of the time?			
Difficulty falling asleep/ staying asleep?			

Life Style

Past/Present	Yes	No	Comments and Notes
What kind of physical activity do you do, and how many times a week?			
Do you smoke?			If so, how many a day?:_____ If you quit, how long did you smoke:_____ How long ago did you quit?:_____
Do you drink more than 2 alcoholic drinks a day?			
Do you drink caffeinated beverages?			
Are you a regular user of sleeping pills, pain killers, marijuana, etc.?			Describe:
Have you ever used heroine, cocaine, LSD, PCP, etc.?			
Do you drive a motor vehicle more than 25,000 miles a year?			
Do you use seatbelts when riding in cars?			

Allergy/Immunologic

Past/Present	Yes	No	Comments and Notes
Hay Fever?			
Drug allergies?			
Food Allergies?			

Childhood Immunizations	Yes	No	
2 Months Comvax, DtaP or Td, Polio, Prevnar			
4 Months Comvax, DtaP or Td, Polio, Prevnar			
12-18 Months Comvax, DtaP or Td, Polio, Prevnar, MMR, Chicken Pox			
2 Year Hepatitis A (2 shots 6 months apart)			
5 Year DtaP or Td, Polio, MMR			
11 year DTaP or Td			

Adult Immunizations	Yes	No	
Tetanus			
Pneumococcal			
TB Skin Test			
Flu			
Other			

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Medications

Present **Comments and Notes**

Prescriptions

Name of Medication:	Dose	How often	Prescribed for

Over the Counter Drugs

Name of Medication	Dose	How often	Taken for

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Past Medical History

Past/Present **Comments and Notes**

Type of Procedure/Test	Date	Results

Hospitalizations

Past/Present

Operation	Year	Hospital Name/City	Surgeon

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Family History

For each member of your family, follow the line across the page and check the boxes indicating: **1**. Their present state of health, **2.** Any illness they have had.	Allergies	Anemia	Blood Disorder	Celiac	Cancer/Tumor	Diabetes	Epilepsy	Glaucoma	Genetic Disease	Gout	Heart Disease	High Blood	Hormonal Problems	Kidney/Bladder	Liver	Mental Illness	Rheumatism or Arthritis	Intestinal
Father																		
Mother																		
Brothers/Sisters																		
Spouse																		
Child																		
Child																		
Child																		

Notes: