NORTHSIDE
FAMILY MEDICINE &
URGENT CARE
CUMMING

PHYSICAL EXAMINATION FORM

Date:____

Patient Name: ______________________________________

DOB:____

Allergies:____

Current Medications (include Rx and over the counter)____________________

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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 veneral 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, 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** **Patient's Signature** **Date**

Reorder #NUCFM_C001
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