Crouse
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New Patient Pre-Examination Information

PATIENT INFORMATION

Name _____ Date of Birth _____ / _____ / _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Emergency Contact _____ Phone _____

Language _____

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino Gender ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Divorced

Current Employer _____ Occupation _____

Do you have a ☐ Health Care Proxy If so, Agent _____
☐ Living Will ☐ DNR ☐ Medical Orders for Life-Sustaining Treatment

PAST HISTORY

Have you ever had (Please check):

☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Disease ☐ Pneumonia ☐ Asthma ☐ Lung Disease

☐ Tuberculosis ☐ Diabetes ☐ Cancer ☐ Ulcers/ Reflux ☐ Hepatitis ☐ Chicken Pox ☐ HIV ☐ Blood Transfusion

☐ Other _____

FAMILY HISTORY

Who in your family has:

Cancer	☐ Father	☐ Mother	☐ Brother (s)	☐ Sister(s)	☐ Other
Lung Disease	☐ Father	☐ Mother	☐ Brother (s)	☐ Sister(s)	☐ Other
Stroke	☐ Father	☐ Mother	☐ Brother (s)	☐ Sister(s)	☐ Other
Tuberculosis	☐ Father	☐ Mother	☐ Brother (s)	☐ Sister(s)	☐ Other
High Cholesterol	☐ Father	☐ Mother	☐ Brother (s)	☐ Sister(s)	☐ Other
Diabetes	☐ Father	☐ Mother	☐ Brother (s)	☐ Sister(s)	☐ Other
Heart Disease	☐ Father	☐ Mother	☐ Brother (s)	☐ Sister(s)	☐ Other
High Blood Pressure	☐ Father	☐ Mother	☐ Brother (s)	☐ Sister(s)	☐ Other
Osteoporosis/Arthritis	☐ Father	☐ Mother	☐ Brother (s)	☐ Sister(s)	☐ Other
Mental Illness	☐ Father	☐ Mother	☐ Brother (s)	☐ Sister(s)	☐ Other

PATIENT NAME _____ Date of Birth _____ / _____ / _____

PRE-EXAMINATION INFORMATION

Have you had any operations or been a patient in a hospital? ☐ No change since last visit or last physical

Type/Reason	Year	Hospital/Location	Physician/Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list present medication with dosage and how taken: (bring in all medicines to your appointment)

Medicine	Dosage	Medicine	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you use non-prescription medicines, diet supplements, vitamins, calcium, iron? ☐ Yes ☐ No If yes, please list:_____

_____

Please list any allergies to medications and your reaction:

_____

_____

Did you ever smoke? ☐ Yes ☐ No Do you smoke now? ☐ Yes ☐ No

If yes, how much? _____ What? _____ How long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, what and how much? _____

Have you ever used illegal substances? ☐ Yes ☐ No

Have you had immunizations?

☐ Shingles: Year_____ ☐ Pneumovax: Year_____ ☐ Tetanus: Year_____ ☐ Flu:Year_____

Have you had any of the following?

☐ Chest X-ray ☐ CT Scan ☐ MRI ☐ Barium Enema ☐ Tuberculin Skin Testing ☐ Stress Test ☐Sigmoid/Colonoscopy ☐ GI Series

List other doctors you see:

_____

_____

What is your weight? _____ Height? _____ Has it changed in the last 6 months? ☐ Yes ☐ No Gain_____ Lost_____

Do you sleep well? ☐ Yes ☐ No How many hours?_____ Has it changed in the last 6 months? ☐ Yes ☐ No

Have you ever been employed in an area that exposed you to hazardous infections or substances? ☐ Yes ☐ No

If yes, explain: _____

Do you follow any special diet? ☐Yes ☐ No If yes, explain: _____

Amount of coffee, tea, cola daily: _____ Amount of salt ☐ Large ☐ Medium ☐ Small

FOR MEN AND WOMEN:

Are you sexually active? ☐ Yes ☐ No Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

FOR WOMEN ONLY:

Name of OB/GYN Physician: _____ Date of last pap smear _____

Date of last mammography _____ Date of last bone density _____

Date of last breast examination _____ Do you do self- exams? ☐ Yes ☐ No

PATIENT NAME _____ Date of Birth _____ / _____ / _____

MENSTRUAL HISTORY:

Age at onset_____ Length of cycle (between periods) _____ Days of flow _____

□ Heavy □ Medium □ Light Are they regular? □ Yes □ No Pain or Cramps? □ Yes □ No

Date of last period _____ Vaginal discharge_____

PREGNANCIES:

How many pregnancies? _____ How many miscarriages? _____ Any stillbirths? _____

Any complications? □ Yes □ No If yes, explain _____

FOR MEN ONLY:

Date of last PSA _____ Date of last rectal exam _____ Do you perform regular testicular exams? □ Yes □ No

SYMPTOMS

Are you having (please check):

EYES
- □ Blurred or Double Vision
- □ Glaucoma
- □ Cataracts
- □ See floating spots
- □ Wear glasses, contact lenses
- □ Macular Degeneration

EARS/NOSE/THROAT
- □ Deafness/hearing aids
- □ Earaches
- □ Ringing in ears
- □ Frequent colds/hoarseness/ sore throat
- □ Nose bleeds
- □ Swollen glands
- □ Runny nose, post nasal drip
- □ Phlegm/sputum
- □ False teeth
- □ Bleeding from teeth or gums
- □ Difficulty chewing
- □ Sores on your tongue

CHEST
- □ Asthma
- □ Persistent cough
- □ Wheezing
- □ Lung disease
- □ Snoring
- □ Sleep apnea
- □ Shortness of breath
- □ Pain/pressure/discomfort in chest
- □ Palpitations/irregular beats
- □ Heart trouble
- □ High blood pressure
- □ Dizziness/fainting
- □ Blood clots in lungs or legs
- □ Swelling in ankles
- □ Discomfort in legs when walking or at rest

ABDOMEN
- □ Indigestion/heartburn
- □ Nausea/vomiting
- □ Hiatal hernia
- □ Ulcers
- □ Gallbladder problems
- □ Loss of appetite
- □ Intolerance of certain foods
- □ Abdominal pain
- □ Pulse sensation
- □ Change in bowel habits
- □ Diarrhea
- □ Constipation
- □ Bloody/black bowel movements
- □ Pain in rectum
- □ Hemorrhoids (piles)

URINARY TRACT
- □ Kidney or bladder trouble
- □ Discomfort passing urine
- □ The urge to urinate at night
- □ Loss of urine when coughing or sneezing
- □ Trouble making a steam
- □ Reoccurring urinary tract infections
- □ Kidney stones
- □ Difficulty with sexual ability
- □ Venereal disease

LYMPH NODES
- □ Swelling

MUSCLES/NERVES
- □ Difficult to walk or stand
- □ Broken bones
- □ Arthritis
- □ Bursitis
- □ Pain/swelling in joints
- □ Muscle weakness
- □ Back pain/problems
- □ Headaches, frequent/severe
- □ Migraine headaches
- □ Convulsions/seizures
- □ Paralysis
- □ Tremor
- □ Pain/numbness/tingling
- □ Fingers/toes
- □ Around mouth

SKIN
- □ Easily bruised
- □ Sores that won't heal
- □ Rashes
- □ Acne

ENDOCRINE
- □ Ability to tan easily
- □ Feel warmer or colder than the rest of the family
- □ Anemia
- □ See floating spots
- □ Thyroid disease
- □ Diabetes

MENTAL STATUS
- □ Difficult with memory
- □ Depression/suicidal thoughts
- □ Anxiety
- □ Irritability
- □ Feeling of panic

CONSTITUTIONAL
- □ Energy level
- □ Stamina
- □ Fatigue
- □ Fever/chills

_____

Patient Signature Date Reviewed by Date