NORTH ATLANTA MEDICAL CLINIC

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Date:_____

Doctor: **Victorine Nguena**

PHYSICAL EXAM FORM

PLEASE COMPLETE ALL PARTS OF THIS FORM AND ACCURETLY.

NAME:_____ RACE(optional): _____

DOB: _____ SEX: M / F AGE: _____

PAST MEDICAL HISTORY: Please circle whichever item applies-

High blood pressure	Abnormal heart beat	Heart disease
Lung disease	Asthma	Kidney disease
Diabetes	High cholesterol	Thyroid disease
Esophageal reflux	Peptic ulcer disease	Liver disease
Bleeding disorder	Blood clots	Anemia
Arthritis	Rheumatoid arthritis	Osteoporosis
Depression	Mental illness	Seizure disorder
HIV/AIDS	Cancer	Gout

Please list any other medical condition:

PAST SURGICAL HISTORY:

_____

_____

FAMILY HISTORY: Your family – Mother, Father, Brothers, Sisters, Aunts, Uncles, Other family members.

Mother: _____ Father: _____

Family Health Problems: _____

SOCIAL HISTORY: MARITAL STATUS: _____ EDUCATION : _____

ALCOHOL USE: _____ TOBACO USE : _____

DRUG USE: _____ OCCUPATION: _____

EXERCISE (ACTIVITY,DAY PER WEEK):_____

IMMUNIZATION: TETANUS: _____ PNEUMONIA: _____ INFLUENZA: _____HEPATITIS B/A: _____

(shot) MMR: _____ VARICELLA _____HPV_____ OTHER: _____

OB HISTORY: NUMBER OF PREGNANCIES: NORMAL _____ C-SECTION _____

NUMBER OF CHILDREN: _____ NUMBER OF MISCARRIAGES/ABORTIONS: _____

AGE OF CHILDREN: _____

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Doctor: **Victorine Nguena**

PREVIOUS TESTS: PLEASE INDICATE DATE OF PAST DIAGNOSTIC TESTS:

DATE OF LAST PAPSMEAR _____ NORMAL OR ABNORMAL

DATE OF LAST MAMMOGRAM: _____ NORMAL OR ABNORMAL

BONE DENSITY: _____ STRESS TEST: _____

COLONOSCOPY: _____ ECHO TEST: _____

ALLERGIES: Please indicate any allergies to medication that you have and describe type of reaction:

_____

REVIEW OF SYSTEMS: Please circle if you have any of the following symptoms, and give a brief description-

General: Weight gain or loss, loss of appetite,fever,chills,fatigue,nightsweats_____

Head: Headache,diziness,masses,seizures_____

Eyes: Visual changes, eye pain _____

Ears: Tinnitus, vertigo, hearing loss_____

Nose: Nose bleeds, discharge, sinus diseases_____

Mouth and Throat: Dental disease, hoarseness, throat pain_____

Cardiovascular: Chest pain, palpitations, murmur, edema _____

Respiratory: Shortness of breath, wheezing,, cough, sputum color,_____

Gastrointestinal: Abdomen pain, nausea, vomiting, constipation, diarrhea, rectal bleeding, swallowing difficulty_____

Genitourinary: Pain with urination, increase frequency, hesitating, dribbling, bleeding, incontinence, prostate issues, penile discharge _____

Gynecologic: Breast masses, pain, discharge_____

Vaginal bleeding, pain, disharge_____

menopause_____ Date of last menstrual period(frequency, duration): _____

Menstruation problems _____

Any Birth control use ?Yes/No_____ Are you sexually active? Yes / No_____

Is there any chance you could be pregnant now? _____

Any history of STD _____

Neuropsychiatry: Weakness, seizures, memory changes, depression, loss of balance/coordination, anxiety, hallucinations, sleeps disturbances _____

Endocrine: Excessive thirst, increase urination, heat/cold intolerance, skin or hair changes , fatigue _____

Skin: Any rashes or lesions, changes in moles _____

Blood and Lymph: Easy bruising, anemia, lymph nodes enlargement_____

Allergic and Immunology: Wheezing, eczema, itching, hives_____

Musculoskeletal: Joint pain or swelling, arthritis, muscle ache, numbness or tingling,back pain_____

Other problems: _____

PLEASE SIGN FORM HERE: Patient: _____ Date: _____

Physician: _____ Date: _____