



# SUMMIT MEDICAL GROUP

## History & Physical

(To Be Completed by Patient)

NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_

REASON FOR VISIT \_\_\_\_\_  
\_\_\_\_\_

ALLERGIES TO MEDICATIONS:

TYPE OF REACTION:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE DESCRIBE ANY PREVIOUS SURGERIES (With approximate dates):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST ALL SERIOUS ILLNESSES (And any medical diagnosis given in the past i.e. Diabetes, Angina, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST CURRENT MEDICATIONS (Include over the counter and birth control):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY:** If there is no change since your last exam, check here \_\_\_\_\_

Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_

Occupation \_\_\_\_\_ Retired \_\_\_\_\_

Hobbies/Interests \_\_\_\_\_

Travel Outside the United States \_\_\_\_\_ Where \_\_\_\_\_

Exposure to environmental agents? \_\_\_\_\_

**DO YOU:**

Exercise regularly? Yes \_\_\_\_\_ No \_\_\_\_\_ Type \_\_\_\_\_ Times /Week \_\_\_\_\_

Smoke? No \_\_\_\_\_ Yes \_\_\_\_\_ Packs per day \_\_\_\_\_ for # of years \_\_\_\_\_ Year you quit \_\_\_\_\_

Drink Alcohol? No \_\_\_\_\_ Drinks per week \_\_\_\_\_ Type: (Wine/Beer/Liquor) \_\_\_\_\_

If no, did you ever drink in the past? \_\_\_\_\_ Amount \_\_\_\_\_, How many years did you drink \_\_\_\_\_

Year you quit \_\_\_\_\_

Take in Caffeine? No \_\_\_\_\_ Yes \_\_\_\_\_ Cups per day \_\_\_\_\_

Use of recreational drugs? No \_\_\_\_\_ Yes \_\_\_\_\_

**IMMUNIZATIONS:** Please list year of last shot given.

Pneumonia \_\_\_\_\_ Tetanus \_\_\_\_\_ Adacel \_\_\_\_\_ Flu \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Hepatitis A \_\_\_\_\_

Zostavax \_\_\_\_\_ Last skin test for TB \_\_\_\_\_ Normal/Abnormal \_\_\_\_\_

Do you have a living will? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please provide us with a copy for our records.

**FAMILY HISTORY:** Please list any illnesses or deaths in the family. If no change since last visit with us, check here \_\_\_\_\_

	AGE	ALIVE	HEALTH PROBLEMS
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
BROTHER(S)	_____	_____	_____
	_____	_____	_____
SISTER(S)	_____	_____	_____
	_____	_____	_____
CHILDREN	_____	_____	_____
	_____	_____	_____
GRANDFATHERS	_____	_____	_____
	_____	_____	_____
GRANDMOTHERS	_____	_____	_____
	_____	_____	_____

**PLEASE LIST THE LAST TIME YOU HAD:**

a) An eye exam month \_\_\_\_\_/year \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

b) For females 1) Pap/pelvic exam month \_\_\_\_\_/year \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

2) Breast exam month \_\_\_\_\_/year \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

3) Mammogram month \_\_\_\_\_/year \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

c) Date of last medical exam \_\_\_\_\_ Date of last lab test \_\_\_\_\_

Use of alternative Doctors or medical therapies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any other items you are concerned about or want to discuss with the doctor?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Below please list any test or procedures done since your last physical exam, ie: Colonoscopy, CT Scans Sonograms, Kidney/Intestinal X-Rays or procedures, Stress Test etc. with approximate dates, reason for test (if known to you) and the Doctor who ordered the test in case more information is needed.

	<u>Procedure or Test Done</u>	<u>Approx. Date of Testing</u>	<u>Reason for Test</u>	<u>Result of Test</u>	<u>Ordering Doctor</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Date)

\*If there is anything you feel uncomfortable reporting on these forms, please feel free to discuss it in private with your Physician. Thank you for taking the time and assisting us with your health care.