

Global Care Medical Group, P.C.

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History & Physical

Name: _____ Date of Birth: _____
 Address: _____ Occupation: _____
 Tel. (Home): _____ (Work): _____ (Cell): _____

Former or present illnesses (Please check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthritis or Gout | <input type="checkbox"/> Anemia | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Blood _____Legs |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Diabetes | _____Lungs |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma, Hay Fever | <input type="checkbox"/> Headaches | _____ |
| <input type="checkbox"/> Hives, Eczema | <input type="checkbox"/> Thyroid | _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease | _____ |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumor/Cancer | _____ |
| <input type="checkbox"/> Allergies (to medicines, food, etc.) _____ | | |

Hospitalizations:

| Date | Reason | Hospital |
|------|--------|----------|
| | | |
| | | |
| | | |

Medicines you are now taking (including all prescription and over-the-counter medications, i.e. aspirin, laxatives, vitamins, etc.):

Date of last (write date in box below):

| | | | | |
|-------------|------------|---------|--------------|---------|
| Chest X-Ray | Cardiogram | TB Test | Tetanus Shot | Unknown |
|-------------|------------|---------|--------------|---------|

- | | |
|---|--|
| 1. Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Did you smoke in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Do you use drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Are you married/widowed/divorced? ____ 7. Do you feel safe at home? <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Gyn History: Onset Age _____ 9. Number of Pregnancies: _____ | Have you ever tried to quit smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of packs smoked per day? _____ How much? _____ How often? _____ How much? _____ How often? _____ How much? _____ How often? _____ Do you have a partner? <input type="checkbox"/> Male <input type="checkbox"/> Female Have you been abused sexually, emotionally or physically? _____ Regular periods? <input type="checkbox"/> Yes <input type="checkbox"/> No Menopause Age: _____ Number of Live Births: _____ |
|---|--|

Blood Relatives with (Please check all that apply):

- | | | | | | |
|---|---|---------------------------------|--|---------------------------------|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> TB | <input type="checkbox"/> Cancer | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Alcohol Problems | | | | | |

In Case of Emergency, please notify:

Name: _____ Relation: _____ Phone #: _____

Reviewed by: _____ Date: _____