Scala Medical

Internal Medicine and Pediatrics

Physician Care

Patient Name: Last _____ First _____ **DOB:** ___/___/___

Sex: M__F__Transgender __ **Marital Status:** S__ M__ D __ W __ Legally separated __ Partner__

Previous or referring doctor: _____ **Date of last physical exam:** _____

Personal Health History

Childhood Illness: __Measles __Mumps __Rubella __Chickenpox __Rheumatic Fever __Polio

Immunizations and dates:	__ Tetanus	__ Pneumonia
	__ Hepatitis	__ Chickenpox
	__ Influenza	__ MMR

List any medical problems that other doctors have diagnosed:

Have you ever had a blood transfusion? __ Yes __ No

Surgeries		
Year	**Reason**	**Hospital**

Other Hospitalizations		

List your prescribed medications and OTC drugs such as vitamins or inhalers		
Drug Name	**Strength**	**Frequency Taken**

Allergies to medications	
Drug Name	**Reaction**

Health Habits and Personal Safety

**ALL QUESTIONS ARE OPTIONAL AND ARE PROTECTED BY HIPAA CONFIDENTIALITY LAWS

Exercise	__Sedentary (no exercise)			
	__ Mild Exercise (stairs, walking a few times a week)			
	__ Occasional vigorous exercise (work or recreation, Less than 4x week for 30+ min)			
	__ Regular vigorous exercise (work or recreation, 4x/week for 30+ min)			
Diet	Are you dieting __Y __N if yes, is it a physician prescribed diet? __Y __N			
	# of meals in an average day?			
	Rank salt intake	__ HIgh	__ Med	__ Low
	Rank fat intake	__ HIgh	__ Med	__ Low

Caffeine	__ None	__ Coffee # ____	__ Tea #____	__ Cola # ____
Alcohol	__ Y __ N	# per day/week ___/___ What kind (beer, etc):		
Tobacco	__ Y __ N	Cigarettes # pks/day _____	Chew #/day _____	
Pipe #/day ____	Cigars #/day____	# Years :	Year quit:	

Illegal Drugs: Do you currently use recreational or street drugs? __Y __N

Type(s): Have you used or shared a needle? __ Y __N

Sex	Are you sexual active? __Y __N if yes, are you trying to become pregnant __Y __N			
	If no, are you using contraception and if so, what type?:			
	Any discomfort with intercourse? __Y __ N			
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk for this illness? __Y __N			
Personal Safety	Do you live alone? __Y __ N		Frequent Falls? __Y __ N	
	Do you have hearing or vision loss? __ Y __ N			
	Do you have an Advance Directive or Living Will? __ Y __ N			
	Would you like information on an Advance Directive or Living Will? __ Y __ N			
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical abuse. Would you like to discuss this issue with your provider? __Y __ N			

Mental Health

Is stress a major problem for you? __Y __ N
Do you feel depressed? __ Y __ N
Do you panic when stressed? __ Y __ N
Do you have problems with eating or your appetite? __ Y __ N
Do you cry frequently? __Y __ N
Have you ever attempted suicide? __Y __ N
Have you ever seriously thought about hurting yourself? __Y __ N
Do you have trouble sleeping? __Y __ N
Have you ever been to a counselor? __Y __ N

Other Problems

Check if you have, or have had, any symptom in the following areas to a significant degree and briefly explain:		
o Skin	o Chest/Heart	o Recent changes in:
o Head/Neck	o Back	o Weight
o Ears	o Intestinal	o Energy Level
o Nose	o Bladder	o Ability to sleep
o Throat	o Bowel	o Other pain/discomfort
o Lungs	o Circulation	

Family Health History

	Age	Significant Health Problems		Age	Significant Health Problems
Father			**Children**		
Mother					
Sibling					
			Grandmother (Maternal)		
			Grandfather (Maternal)		
			Grandmother (Paternal)		
			Grandfather (Paternal)		

Women Only
Age at onset of menstruation: Date of last menstration:
Period every _____ days Heavy periods, irregularity, spotting, pain or discharge? __Y __ N
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around your period? __ Y __ N
Number of pregnancies ____ Number of live births ____ Are you pregnant or breast feeding? __ Y __ N
Have you had a D&C, hysterectomy or Cesarean? __Y __ N if yes, which one and what year(s) _____
Any urinary tract, bladder or kidney infections within the last year? __Y __ N Do you urinate at night? __ Y __ N
Any problems controlling urination? __Y __ N if yes, do you leak urine when standing, coughing or laughing? __Y __ N
Any hot flashes or sweating at night? __ Y __ N
Experienced any recent breast tenderness, lumps or nipple discharge? __Y __ N if yes, describe:
Date of last pap and rectal exam:

Men only
Do you urinate at night? __ Y __ N if yes, # of times _____ Pain or burning with urination? __ Y __ N
Blood in your urine? __ Y __ N Has the force of your urination decreased? __ Y __ N
Have you had any kidney, bladder or prostate infections within the last year? __ Y __ N if yes, describe:
Do you have problems emptying your bladder completely? __ Y __ N
Any difficulty or pain with erection or ejaculation? __ Y __ N
Any testicle pain or swelling? __ Y __ N
Do you feel burning discharge from your penis? __ Y __ N Have you recently had unprotected intercourse with a new partner? __ Y __ N
Date of last prostate and rectal exam:

Provider signature: _____ **Date:** _____