# GAMA Practices History and Physical

DATE _____

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

**PREVIOUS PHYSICIAN** _____ LAST SEEN _____

ADDRESS _____ CITY _____ STATE/ZIP _____

**OTHER PHYSICIANS SEEN REGULARLY**

NAME _____ SPECIALTY _____ PHONE # _____ LAST SEEN _____

NAME _____ SPECIALTY _____ PHONE # _____ LAST SEEN _____

NAME _____ SPECIALTY _____ PHONE # _____ LAST SEEN _____

NAME _____ SPECIALTY _____ PHONE # _____ LAST SEEN _____

**SOCIAL HISTORY**

BIRTH PLACE _____ EDUCATION _____

RELIGION _____ EMPLOYMENT _____

MARITAL STATUS _____ # OF CHILDREN/GRANDCHILDREN _____

DOES SOMEONE ELSE DEPEND ON YOU AS A CAREGIVER? _____

ALCOHOL INTAKE _____ SMOKING HISTORY _____

DO YOU ALWAYS USE A SEATBELT? _____ HAVE YOU USED STREET DRUGS? _____

DO YOU HAVE SMOKE DETECTORS? _____ DO YOU EXERCISE REGULARLY? _____

**FAMILY HISTORY**

| | MEDICAL HISTORY | ALIVE | DECEASED |
|---|---|---|---|
| MOTHER: | | | |
| FATHER: | | | |
| SIBLINGS: | | | |
| | | | |
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# Health History

NAME _____ DATE OF BIRTH _____

**MEDICAL PROBLEMS**

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**SURGERIES**

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**CURRENT MEDICATIONS** (Include non-prescription drugs and vitamins)

| MEDICATION | DOSE | FREQUENCY |
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**ALLERGIES**

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# Self Reported History

NAME _____ DATE OF BIRTH _____

Describe general health compared to others the same age: ____Excellent _ _ Good _ _ Fair _ _ Poor

General health over the past five years _____

_____

Weight: Changes in the past 6 months _____ Past year _____

Describe typical day/hobbies _____

_____

Have you ever been bothered by feeling down, depressed, or hopeless? Yes No

Have you often been bothered by little interest or pleasure in doing things? Yes No

**FUNCTIONAL STATUS**

Are you able to: (Circle what applies: I= INDEPENDENTLY, A= WITH ASSISTANCE, D= DEPENDENT ON OTHERS FOR HELP)

| | I | A | D | | I | A | D |
|---|---|---|---|---|---|---|---|
| GET DRESSED | ● | ○ | ○ | DRIVE | ● | ○ | ○ |
| BATHE | ● | ○ | ○ | USE PHONE | ● | ○ | ○ |
| USE TOILET | ● | ○ | ○ | MANAGE MONEY | ● | ○ | ○ |
| EAT | ● | ○ | ○ | PREPARE MEALS | ● | ○ | ○ |
| WALK | ● | ○ | ○ | SHOP | ● | ○ | ○ |

Do you use: _ _walker ____cane _ _commode ____raised toilet seat _ _hospital bed ____wheelchair

Other assistive devices: _____

_____

**IMMUNIZATION STATUS**

TETANUS _____ PPD _____ INFLUENZA _____ PNUEMOVAX _____

**ADVANCED DIRECTIVES**

Do you have a health care proxy? Yes No NAME _____

Do you have a living will? Yes No

# Review of Systems (Please check all symptoms you have had in the last 6 months)

**GENERAL**
- ___ Insomnia
- ___ Fatigue
- ___ Weight Loss/Gain
- ___ Change in Appetite
- ___ Cold or Heat Intolerance

**SKIN**
- ___ Lesions
- ___ Wounds
- ___ Pigmentation Changes
- ___ Hair/Nail Changes
- ___ Abnormal Bleeding/Bruising

**EYES**
- ___ Vision Changes
- ___ Pain
- ___ Cataracts
- ___ Glaucoma
- ___ Double Vision
- ___ Photophobia
- ___ Infections
- ___ Glasses/Contacts

**EARS**
- ___ Hearing Changes
- ___ Drainage
- ___ Ringing
- ___ Vertigo
- ___ Infections
- ___ Hearing Aid (R, L, Both)

**NOSE & SINUSES**
- ___ Drainage
- ___ Bleeding
- ___ Snoring
- ___ Pain
- ___ Post Nasal Drip
- ___ Infections

**MOUTH & THROAT**
- ___ Lesions/Ulcers
- ___ Hoarseness
- ___ Voice Changes
- ___ Difficulty Swallowing/Chewing
- ___ Sore Throat

**BREASTS**
- ___ Lumps/Masses
- ___ Pain
- ___ Nipple Discharge
- ___ Skin Changes

**RESPIRATORY**
- ___ Cough
- ___ Pneumonia
- ___ Shortness of Breath
- ___ Wheezing

**CARDIOVASCULAR**
- ___ Chest Pain
- ___ Palpitations
- ___ Shortness of breath with exertion
- ___ Ankle Swelling
- ___ Leg Pain When Walking
- ___ Stroke or TIA

**GI**
- ___ Nausea or Vomiting
- ___ Indegestion
- ___ Heart Burn
- ___ Ulcers
- ___ Change in Bowel Habits
- ___ Diarrhea/Constipation
- ___ Hemorrhoid

**GU**
- ___ Pain / Burning with Urination
- ___ Frequency/Hesitancy
- ___ Urgency
- ___ Incontinence
- ___ Bladder Infection
- ___ Do you awaken to urinate? How Often? _____

**MUSCULOSKELETAL**
- ___ Joint Pain
- ___ Stiffness
- ___ Joint Swelling
- ___ Cramping
- ___ Muscle Weakness
- ___ Gait Problems/Falls
- ___ Fractures? _____

**NEURO/PSYCHOSOCIAL**
- ___ Headache
- ___ Seizures
- ___ Fainting
- ___ Coordination Problem
- ___ Head Injury
- ___ Memory Issue
- ___ Anxiety/Depression

**REPRODUCTIVE: MALE**
- ___ Penile Discharge
- ___ Lesions
- ___ Impotence
- ___ Inadequate Erections
- ___ Prostate Problems
- ___ Cancer

**REPRODUCTIVE: FEMALE**
- ___ Vaginal Discharge/Bleeding
- ___ Lesions
- ___ Infections
- ___ Pain with intercourse
- ___ Abnormal PAP Smear?
- ___ Taken any hormonal therapy?

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Name of person completing this form _____

Relationship to Patient _____