



# KUHAR MEDICAL

Internal Medicine, PC • Cosmetic Services

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Phone: 215.258.3810 • Fax: 215.258.3815

Polly James, CRNP  
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Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Occupation: \_\_\_\_\_

Social Sec #: \_\_\_\_\_

Single | Divorced | Widowed | Separated

If Married, Spouse's Name \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: Male | Female

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Children Names & ages \_\_\_\_\_

**Allergies to Medications, X-ray Dyes, or Other Substances** (If yes, please list name of medicine and type of reaction)

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

**Social History**

Do you presently smoke? YES NO

Have you ever been a significant smoker? YES NO

Do you use any illicit drugs? YES NO

How much alcohol do you drink weekly? \_\_\_\_\_

**Past Medical History and Review of Systems**

Please circle if you have had problems with or are presently complaining of any of the following:

- |                         |                          |                                  |                          |
|-------------------------|--------------------------|----------------------------------|--------------------------|
| 1. High Blood Pressure  | 13. Bronchitis           | 25. Ulcers                       | 37. Difficulty urinating |
| 2. Diabetes             | 14. Pneumonia            | 26. Change in bowel habits       | 38. Arthritis            |
| 3. Cancer               | 15. Persistent Cough     | 27. Unexplained weight gain/loss | 39. Low back problems    |
| 4. Heart Disease        | 16. T.B.                 | 28. Hemorrhoids                  | 40. Skin disease         |
| 5. Chest pain/tightness | 17. Hay Fever            | 29. Gall bladder disease         | 41. Venereal             |
| 6. Shortness of breath  | 18. Abdominal discomfort | 30. Colitis                      | 42. Anxiety              |
| 7. Swollen ankles       | 19. Indigestion          | 31. Hepatitis or Jaundice        | 43. Blood disorders      |
| 8. Palpitations         | 20. Nausea               | 32. Thyroid disease              | 44. Depression           |
| 9. Lightheadedness      | 21. Vomiting             | 33. Head or neck radiation       | 45. Anemia               |
| 10. Frequent Urination  | 22. Constipation         | 34. Headache                     | 46. Alcohol abuse        |
| 11. Rheumatic Fever     | 23. Diarrhea             | 35. Kidney disease               | 47. Drug abuse           |
| 12. Asthma              | 24. Blood in stool       | 36. Kidney stones                | 48. Gout                 |

**Gynecologic and Obstetric History**

Age at Onset of Periods: \_\_\_\_\_

Frequency: \_\_\_\_\_

Length of

Pregnancies: \_\_\_\_\_ Birth: \_\_\_\_\_

Period: \_\_\_\_\_

Prolonged or Abnormal Bleeding: NO YES

Please describe: \_\_\_\_\_

Leakage of Urine: NO YES

Please describe: \_\_\_\_\_

Pelvic Pain: NO YES

Please describe: \_\_\_\_\_

Abnormal Discharge: NO YES

Please describe: \_\_\_\_\_

History of Abnormal Pap Smear: NO YES

Please describe: \_\_\_\_\_

**Medications (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.):**

Drug Name

Drug Name

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

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



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**Please list and supply the dates of:**

Operations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations other than for surgery: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Immunization History:** (Have you had any of the following & if so, when?)

Pneumovax Immunization	_____ YES	_____ NO	Hepatitis A	_____ YES	_____ NO
Influenza Immunization	_____ YES	_____ NO	Hepatitis B	_____ YES	_____ NO
Tetanus Immunization	_____ YES	_____ NO	Varicella	_____ YES	_____ NO
Tuberculosis Test	_____ YES	_____ NO	MMR	_____ YES	_____ NO

Other: \_\_\_\_\_

**Routine Exams:** (Have you had any of the following & if so, when?)

Mammogram	_____ YES	_____ NO	Breast Exam	_____ YES	_____ NO
DexaScan	_____ YES	_____ NO	PAP Smear	_____ YES	_____ NO
Cholesterol Check	_____ YES	_____ NO	Colonoscopy	_____ YES	_____ NO
Prostate Exam	_____ YES	_____ NO	EKG	_____ YES	_____ NO
Stool Check for Blood	_____ YES	_____ NO			

**Family History:**

Has any member of your family (including parents, grandparents, children, and siblings) ever had the following?

<i>Illness</i>	<i>Which family member(s)?</i>	<i>Approx. age when discovered?</i>
Cancer (describe type)	_____	_____
Hypertension	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental Disease (anxiety, depression, etc.)	_____	_____
Drug or Alcohol Addiction	_____	_____
Glaucoma	_____	_____
Colon Polyps	_____	_____

Are your parents still alive? \_\_\_ YES \_\_\_ NO if so, age(s)? \_\_\_\_\_

**Prevention:**

Do you wear seatbelts?	_____ YES	_____ NO	If no, why not? _____
Do you wear a bike helmet?	_____ YES	_____ NO	_____ N/A
Do you drink coffee?	_____ YES	_____ NO	If yes, how many cups per day? _____
Do you drink tea?	_____ YES	_____ NO	If yes, how many cups per day? _____
Is there a gun in your home?	_____ YES	_____ NO	_____ N/A

Have you ever engaged in any activity which:

Has put you at risk of getting AIDS?	_____ YES	_____ NO	If yes, explain _____
Do you wish to get tested for AIDS?	_____ YES	_____ NO	
Have you ever worked with chemicals, paints, asbestos, or hazardous materials?			If yes, explain _____

Are you in a physically abusive relationship?	_____ YES	_____ NO	
Do you ever feel afraid of your partner?	_____ YES	_____ NO	_____ N/A
Do you have a living will?	_____ YES	_____ NO	
Do you have a donor card?	_____ YES	_____ NO	
Method of birth control?	_____ YES	_____ NO	If yes, explain _____

\*\*\*This information is used by your physician as part of your confidential medical record.\*\*\*



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