Dr. Nadu A. Tuakli, M.D.

History & Physical

Name ___________________________
Date ___________ SS# ____________
Address _________________________
____
Occupation ______________________
Phone (Home) ____________________
Phone (Work) ____________________
Date Of Birth ________________
Chief Complaint __________________

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

Hospitalization or Surgery

Date	Reason		Date	Reason

Medications

____

Drug Allergies

____
____
____

Vaccinations (year of last):	Test/Exam (Year of Last):
Tetanus	Rectal/Stool
Flu	Cholesterol
Pneumonia	Tuberculosis
Other________	Other_________

PERSONAL MEDICAL HISTORY (INCLUDE DATES)

o Abdominal Pain - Chronic
o Allergies/Hayfever
oAnemia oBruise Easily
o Ankles - Swollen
o Appetite - Loss Of
o Arthritis/Rheumatism
o Asthma/Wheezing
o Back Pain - Recurrent
o Bone Fracture/Joint Injury
o Bowel Habits - Change In
o Bronchitis/Chronic Cough
o Cancer
o Chest Pain
o Convulsions/Seizures
o Crohn's/Colitis
o Diabetes
o Diarrhea o Constipation
o Diptheria
o Diverticulosis
o Dizziness/Fainting
o Ear Infections - Frequent
o Ear - Ringing in
o Eye Infections
o Fatigue - Chronic
o Foot Pain o Cold Numb Feet
o Gall Bladder Trouble
o Gout
o Hair Loss
o Headaches - Frequent
o Heart Murmur
o Hemorrhoids
o Hernia

o High Blood Pressure
o Indigestion or Heartburn
o Infections - Frequent
o Jaundice/Hepatitis
o Kidney Stones
o Lactose Intolerance
o Leg Pain - Walking
o Memory Loss
o Mental Illness
o Moodiness - Excessive
o Muscle Weakness
o Nausea/Vomiting - Persistent
o Nervousness o Depression
o Nose Bleeds
o Numbness/Tingling
o Osteoporosis
o Phobias
o Pneumonia
o Prostate Disease
o Psoriasis o Eczema
o Rashes o Hives
o Sexual/Menstrual Dysfunction
o Sinus Trouble
o Stools - Bloody or Tarry
o Stroke
o Swallowing Difficulty
o Tetanus
o Throat - Sore - Frequent
o Thyroid Disease
o Tremor/Hands Shaking
o Ulcers - Peptic
o Urethral Discharge

o Urination o Overnight > than twice
o Decrease in Force/Flow
o Painful o Loss of Control
o Urine - Blood In
o Varicose Veins/Phlebitis
o Venereal Disease
o Vision - Failing
o Weight Loss - Recent
o Chicken Pox o Polio o Mumps
o Measles o Rubella o Rheumatic Fever
o Scarlet Fever o Tuberculosis o Herpes
o Other ______________
o Other ______________

Females - Please Complete

Pregnant? o Yes o No
Planning Pregnacy? O Yes o No
Menstrual Flow:
o Regular o Irregular o Pain/Cramps
o Regular o Irregular o Pain/Cramps
__ Days Of Flow __ Length Of Cycle
Date-1st Day of Last Period ________
o Pain/Bleeding During or After Sex
Number of:
___Pregnancies ___Abortions
___Miscarriages ___Live Births
Birth Control Method_____________
B.C. Pill (Name) _________________
o Flushing/Menopause
Date of Last PAP Test ____________
o Normal o Abnormal
Date of Last Mammogram __________
o Normal o Abnormal

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FAMILY HISTORY

For each item, Circle Yes or No. If Yes, please provide details in the box below. Include which family members and dates.

		Details:
Yes / No	Alcoholism	
Yes / No	Asthma	
Yes / No	Bleeding Disorder	
Yes / No	Cancer	
Yes / No	Diabetes	
Yes / No	Epilepsy/Convulsions	
Yes / No	Glaucoma	
Yes / No	Hair Loss	
Yes / No	Heart Disease	
Yes / No	High Blood Pressure	
Yes / No	Kidney Disease	
Yes / No	Mental Illness	
Yes / No	Migraine	
Yes / No	Osteoporosis	
Yes / No	Stroke	
Yes / No	Thyroid Disease	
Yes / No	Other____________	

Habits

o Alcohol: Type ___________
Amount _________

o Diet: Salt Intake _________________________
Fat Intake _______________________________
Other __________________________________

o Sleep: Difficulty Falling Asleep ____________
Continuity Disturbances __________________
Early Morning Awakening _________________
Daytime Drowsiness ______________________
Other _________________________________

o Coffee: Cups Daily ______
Other Caffeine __________
____

Exercise Routine: ________________________
____

Sexual Practices __________________________
____

o Smoke: Packs Daily _____________
How Long _____________________
Interested in Stopping? __________________

This is my complete medical history to the best of my knowledge.

____
Patient Signature

____
Date

I hereby affirm that my medical history has been reviewd with Dr. Tuakli.

_______________________ _____________
Patient Signature Date

_______________________ _____________
Dr. Nadu A. Tuakli, M.D. Date