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Occupational and Environmental Life Science

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HISTORY & PHYSICAL

NAME _____
DATE _____ SS# _____
ADDRESS _____
OCCUPATION _____ PHONE (HOME) _____
(WORK) _____ DATE OF BIRTH _____
CHIEF COMPLAINT _____
INSURANCE# _____

HOSPITALIZATION OR SURGERY

DATE	REASON	DATE	REASON

DRUG ALLERGIES

MEDICATIONS

VACCINE	YEAR OF LAST	VACCINE	YEAR OF LAST	TEST/EXAM	YEAR OF LAST	TEST/EXAM	YEAR OF LAST
TETANUS		PNEUMONIA		RECTAL/STOOL		TUBERCULOSIS	
FLU		OTHER		CHOLESTEROL		OTHER	

MEDICAL HISTORY

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> RINGING IN EAR _____ | <input type="checkbox"/> PEPTIC ULCERS _____ | <input type="checkbox"/> CONVULSIONS/SEIZURES _____ | <input type="checkbox"/> TETANUS _____ |
| <input type="checkbox"/> EAR INFECTIONS - FREQUENT _____ | <input type="checkbox"/> ABDOMINAL PAIN - CHRONIC _____ | <input type="checkbox"/> STROKE _____ | <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> POLIO <input type="checkbox"/> MUMPS <input type="checkbox"/> |
| <input type="checkbox"/> DIZZINESS/FAINTING _____ | <input type="checkbox"/> GALL BLADDER TROUBLE _____ | <input type="checkbox"/> TREMOR/HANDS SHAKING _____ | <input type="checkbox"/> MEASLES <input type="checkbox"/> RUBELLA <input type="checkbox"/> RHEUMATIC FEVER _____ |
| <input type="checkbox"/> HAIR LOSS _____ | <input type="checkbox"/> JAUNDICE/HEPATITIS _____ | <input type="checkbox"/> MUSCLE WEAKNESS _____ | <input type="checkbox"/> SCARLET FEVER <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> HERPES _____ |
| <input type="checkbox"/> FAILING VISION _____ | <input type="checkbox"/> CHANGE IN BOWEL HABITS _____ | <input type="checkbox"/> NUMBNESS/TINGLING SENSATIONS _____ | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> EYE INFECTIONS _____ | <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION _____ | <input type="checkbox"/> HEADACHES - FREQUENT _____ | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> NOSE BLEEDS _____ | <input type="checkbox"/> DIVERTICULOSIS <input type="checkbox"/> CROHN'S/COLITIS _____ | <input type="checkbox"/> ARTHRITIS/RHEUMATISM _____ | Females - Please Complete |
| <input type="checkbox"/> SINUS TROUBLE _____ | <input type="checkbox"/> BLOODY OR TARRY STOOLS _____ | <input type="checkbox"/> OSTEOPOROSIS _____ | PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> SORE THROATS - FREQUENT _____ | <input type="checkbox"/> HEMORRHOIDS _____ | <input type="checkbox"/> BACK PAIN - RECURRENT _____ | PLANNING PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> HAYFEVER/ALLERGIES _____ | <input type="checkbox"/> HERNIA _____ | <input type="checkbox"/> BONE FRACTURE/JOINT INJURY _____ | Menstrual Flow: |
| <input type="checkbox"/> PNEUMONIA _____ | <input type="checkbox"/> URINE INFECTIONS - FREQUENT _____ | <input type="checkbox"/> GOUT _____ | <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain/Cramps |
| <input type="checkbox"/> BRONCHITIS/CHRONIC COUGH _____ | <input type="checkbox"/> BLOOD IN URINE _____ | <input type="checkbox"/> FOOT PAIN <input type="checkbox"/> COLD NUMB FEET _____ | ____Days of Flow ____Length of Cycle |
| <input type="checkbox"/> ASTHMA/WHEEZING _____ | URINATION- <input type="checkbox"/> OVERNIGHT > THAN TWICE | <input type="checkbox"/> RASHES <input type="checkbox"/> HIVES _____ | Date-1st day of last period _____ |
| <input type="checkbox"/> CHEST PAIN _____ | <input type="checkbox"/> PAINFUL <input type="checkbox"/> LOSS OF CONTROL | <input type="checkbox"/> PSORIASIS <input type="checkbox"/> ECZEMA _____ | <input type="checkbox"/> Pain/Bleeding during or after sex |
| <input type="checkbox"/> HAIR LOSS _____ | <input type="checkbox"/> DECREASE IN FORCE/FLOW | <input type="checkbox"/> NERVOUSNESS <input type="checkbox"/> DEPRESSION _____ | Number of: |
| <input type="checkbox"/> HIGH BLOOD PRESSURE _____ | <input type="checkbox"/> KIDNEY STONES _____ | <input type="checkbox"/> MEMORY LOSS _____ | ____Pregnancies ____Abortions |
| <input type="checkbox"/> HEART MURMUR _____ | <input type="checkbox"/> VENEREAL DISEASE _____ | <input type="checkbox"/> MOODINESS - EXCESSIVE _____ | ____Miscarriages ____Live Births |
| <input type="checkbox"/> SWOLLEN ANKLES _____ | <input type="checkbox"/> URETHRAL DISCHARGE _____ | <input type="checkbox"/> PHOBIAS _____ | Birth Control Method _____ |
| <input type="checkbox"/> LEG PAIN - WALKING _____ | <input type="checkbox"/> CHRONIC FATIGUE _____ | <input type="checkbox"/> MENTAL ILLNESS _____ | B.C. Pill (Name) _____ |
| <input type="checkbox"/> VARICOSE VEINS/PHEBITIS _____ | <input type="checkbox"/> WEIGHT LOSS - RECENT _____ | <input type="checkbox"/> LACTOSE INTOLERANCE _____ | <input type="checkbox"/> Flushing/Menopause |
| <input type="checkbox"/> LOSS OF APPETITE _____ | <input type="checkbox"/> ANEMIA <input type="checkbox"/> BRUISE EASILY _____ | <input type="checkbox"/> PROSTATE DISEASE _____ | Date of Last PAP Test _____ |
| <input type="checkbox"/> DIFFICULTY SWALLOWING _____ | <input type="checkbox"/> CANCER _____ | <input type="checkbox"/> SEXUAL/MENSTRUAL DYSFUNCTION _____ | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> INDIGESTION OR HEARTBURN _____ | <input type="checkbox"/> DIABETES _____ | <input type="checkbox"/> FREQUENT INFECTIONS _____ | Date of Last Mammogram _____ |
| <input type="checkbox"/> PERSISTENT NAUSEA/VOMITING _____ | <input type="checkbox"/> THYROID DISEASE _____ | <input type="checkbox"/> DIPHTHERIA _____ | Normal <input type="checkbox"/> Abnormal |

FAMILY HISTORY

	FATHER	MOTHER	CHILDREN	SIBLINGS	FATHER'S PARENTS	MOTHER'S PARENTS		FATHER	MOTHER	CHILDREN	SIBLINGS	FATHER'S PARENTS	MOTHER'S PARENTS
ALCOHOLISM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MIGRAINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OSTEOPOROSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY/CONVULSIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	THYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAIR LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____						
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							

HABITS

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> ALCOHOL: TYPE _____ | <input type="checkbox"/> SLEEP: DIFFICULTY FALLING ASLEEP _____ | <input type="checkbox"/> SMOKE: PACKS DAILY _____ | <input type="checkbox"/> COFFEE: CUPS DAILY _____ |
| <input type="checkbox"/> AMOUNT _____ | <input type="checkbox"/> CONTINUITY DISTURBANCES _____ | <input type="checkbox"/> HOW LONG _____ | <input type="checkbox"/> OTHER CAFFEINE _____ |
| <input type="checkbox"/> DIET: SALT INTAKE _____ | <input type="checkbox"/> EARLY MORNING AWAKENING _____ | <input type="checkbox"/> INTERESTED IN STOPPING? _____ | |
| <input type="checkbox"/> FAT INTAKE _____ | <input type="checkbox"/> DAYTIME DROWSINESS _____ | <input type="checkbox"/> EXERCISE ROUTINE: _____ | |
| <input type="checkbox"/> OTHER _____ | <input type="checkbox"/> OTHER _____ | | |