CCOM MEDICAL GROUP
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Comprehensive Assessment

Name_____ Age_____ Date of Birth_____ Sex M / F
Primary Medical Problem_____
_____
_____
Other Medical Problems_____
_____
Do you have or have you ever been told you have any of the following?

___Heart Disease	____Anemia	____Thyroid Problems	___Other
___Heart Murmur	____Bleeding Tendencies	____Eye or Ear Problems	_____
___High Blood Pressure	____Other Blood Diseases	____Stomach Ulcer	_____
___Stroke	____Rheumatic Fever	____Gallbladder Disease	_____
___High cholesterol	____Gout	____Liver Disease	_____
___Lung Disease	____Hay Fever	____Bowel Problems	
___Tuberculosis	____Cancer	____Arthritis	
___Diabetes	____Migraine Headaches	____Nervous Condition	
___Kidney Disease	____Asthma	____Osteoporosis	

For the following family members, list any medical problems. If deceased, give cause & age of death.
Father_____
Mother_____
Brother(s)_____
Sister(s)_____
List all current Medications & Dosages_____
_____
_____
_____
Allergies (Write NONE if no known allergies)_____
_____
Type of Reaction_____

Past Surgeries & Dates __Tonsils__/__/____ __Appendix__/__/____ __Heart__/__/____
__ Gallbladder__/__/____ __Abdomen__/__/____ __Extremities__/__/____ __Eye__/__/____

Other_____

Other Hospitalizations_____

FEMALES ONLY: Are you pregnant? Y / N Planning pregnancy? Y / N Last Mammogram__/__/____
Last Pap Smear__/__/____ Last Menstrual Period__/__/____
MALES ONLY: Any diagnosed prostate problems? Y / N Last Prostate exam?__/__/____
Last Physician Seen & Date _____
Other Medical Care not listed elsewhere _____
If you are being treated for any other illnesses or medical problems by another health care provider, please describe the problem(s) below and who is treating you _____

Do you Smoke? _____	How Much? _____	For how long?_____
Drink Alcohol? _____	How Much? _____	For how long?_____
Drink Caffeine Drinks? _____	How Much? _____	For how long?_____
Exercise Routinely? _____	How Much? _____	For how long?_____

OCCUPATION

Are you presently employed? _____
If yes, What kind of work do you do? _____
Are you under a lot of stress in your work? _____
Do you work more than 60 hours a week? _____
Are you or have you been exposed to any chemicals or heavy metals? _____
If yes, what kind? _____

SOCIAL HISTORY

Are you married? _____ Is your present home life causing you unhappiness?_____

Do you Smoke? _____	How Much? _____	For how long?_____
Drink Alcohol? _____	How Much? _____	For how long?_____
Drink Caffeine Drinks? _____	How Much? _____	For how long?_____
Exercise Routinely? _____	How Much? _____	For how long?_____

REVIEW OF SYMPTOMS (Place a check mark next to the symptoms that apply)

GENERAL
__Recent weight loss
__Recent weight gain
__Fever / Chills
__Fatigue / Weakness

SKIN
__Itching
__Rash
__Change in color
__Abnormal growth

EYES
__Blurring
__Pain
__Failing vision
__Double vision
__See "floating lights"

EARS, NOSE, THROAT
__Trouble hearing
__Nose bleeds
__Hoarseness
__Bleeding gums
__Runny nose
__Ears hurting
__Sore throat
__Sinus pain
__Nasal Congestion
__Frequent Colds

NECK
__Swelling in neck
__Stiffness / pain

RESPIRATORY
__Chest congestion
__Cough
__Sputum production
__Coughing of blood
__Shortness of breath
__Wheezing
__Pain on deep breathing

CARDIOVASCULAR
__Use 2 or more pillows at night
__Swelling in feet/ankles
__Shortness of breath
__Shortness of breath at night
__Ever had an abnormal EKG
__Unusual / skipped heartbeats
__Fast hear beat
__Chest pain

GASTROINTESTINAL
__Change in eating habits
__Stomach pain or upset
__Burping a lot
__Trouble swallowing
__Heartburn
__Nausea or vomiting
__Vomiting of blood
__Constipation
__Diarrhea
__Blood from rectum
__Black stool
__Change in bowel movements

GENITOURINARY
__Pain on urination
__Hard to start urinary flow
__Scanty urination
__Blood in urine
__Frequent night urination
__Any leakage of urine
__Kidney stones
__Any retention of urine
__Prostate trouble

GYN/WOMEN
__Breast lumps
__Premenstrual symptoms
__Vaginal itching/ discharge
__Menopause
__Vaginal bleeding

MUSCULOSKELETAL
__Joint or muscle problems
__Shoulder pain
__Back pain
__Pain in walking
__Swelling of joints
__Unsteady walking
__Any muscle jerking
__ Any strokes

CENTRAL NERVOUS SYSTEM
__Headaches
__Dizziness
__Passing out
__Memory loss
__Seizures
__Numbness / Tingling
__Paralysis
__Difficulty swallowing
__Difficulty speaking
__Tremors

NEUROPSYCHOLOGICAL
__Depression
__Nervous breakdown
__Mental Problems
__Psychotherapy / counseling
__Alcohol problem
__Drug problem
__Serious marital problems