# BIKAN S. OCTAIN M.D.P.C

## HISTORY & PHYSICAL

| Name | | SS# | Date |
|---|---|---|---|
| Address | | Occupation | |
| Phone (home) | Work | Date of Birth | Age |
| Chief Complaint | | | |

**DRUG ALLERGIES**

**CURRENT MEDS**

**FAMILY HISTORY**

| | Father | Mother | Father's Parents | Mother's Parents | Siblings | Children |
|---|---|---|---|---|---|---|
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Epilepsy/Convulsions | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bleeding Disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**HOSPITALIZATION OR SURGERY**

| Reason | Date | Reason | Date |
|---|---|---|---|
| | | | |
| | | | |

**MEDICAL HISTORY**

| | | |
|---|---|---|
| ☐ Headache | ☐ Lactose intolerance | ☐ Depression |
| ☐ Short of breath | ☐ Gallbladder disease | ☐ Gout |
| ☐ Heart palpitations | ☐ Prostate disease | ☐ Scarlet fever |
| ☐ Heart murmur | ☐ Bowel irregularity | ☐ Chronic rashes |
| ☐ Chest pain | ☐ Incontinence | ☐ Rheumatic fever |
| ☐ Dizziness/Fainting | ☐ Sexual/menstrual dysfunction | ☐ Mumps |
| ☐ Peripheral vascular disease | ☐ Venereal disease | ☐ Measles |
| ☐ Allergies/Hay fever | ☐ Frequent infections | ☐ Rubella |
| ☐ Asthma | ☐ Hepatitis | ☐ Polio |
| ☐ Bronchitis | ☐ Anemia | ☐ Diphtheria |
| ☐ Pneumonia | ☐ Arthritis | ☐ Tetanus |
| ☐ Ulcer | ☐ Osteoporosis | ☐ Other |
| ☐ GI disorder | ☐ Nervousness | ☐ Other |

**WOMEN ONLY** Pregnant? ☐ Yes ☐ No Planning pregnancy? ☐ Yes ☐ No

**MEN ONLY** *It's common for men to occasionally experience erection difficulties. Is this something that happens to you?* ☐ Yes ☐ No

*How often does this occur?* ☐ Frequently ☐ Sometimes ☐ Rarely

**HABITS**

| | | | | | |
|---|---|---|---|---|---|
| ☐ **Smoke:** | Packs daily | ☐ **Coffee:** | Cups daily | ☐ **Sleep:** | Difficulty falling asleep |
| | How long? | | Other caffeine | | Continuity disturbances |
| | Interested in stopping? | ☐ **Alcohol:** | Type | | Snoring |
| ☐ **Exercise routine:** | | | Amount | | Early morning awakening |
| | | ☐ **Diet:** | Salt intake | | Daytime drowsiness |
| | | | Fat intake | | Other |

# BIKAN S. OCTAIN M.D.P.C

## MEDICAL HISTORY QUESTIONNAIRE

| | | |
|---|---|---|
| Full Name | Social Security Number: | Email |
| Street/#: | Driver's License # | Telephone # |
| Sate: Zip: | State: | |
| Employer: | Name of Insurance Company | Date of Birth: |
| Employer #: ( ) | Phone #: | Sex: ☐ M ☐ F |
| | Member ID: | Height: Weight: |
| Have you ever been diagnosed as having any form of cancer? ☐ Yes ☐ No | Bin #: | Does participant take medication on a regular basis? |
| If yes, When? | PCN #: | ☐ Yes ☐ No |
| | Group #: | |
| | | If Yes, identify: |
| Describe your general health: | | Has patient had or presently experiencing: ☐ Yes ☐ No Allergies |
| Have you had any operations? ☐ Yes ☐ No | | |
| If yes, when/where: | | |
| What is your appetite like: ☐ Normal ☐ Low ☐ Above Average ☐ Other | | |

| | | |
|---|---|---|
| ☐ Yes ☐ No Hypertension | ☐ Yes ☐ No Hypotension | ☐ Yes ☐ No Diabetes |
| Physical activities, frequency/level of energy: ☐ Low ☐ Medium ☐ High ☐ Extreme | ☐ Yes | ☐ No Chronic Illness/es |
| Cardiovascular Problems: ☐ Yes ☐ No | ☐ Yes ☐ No By-pass | ☐ Yes ☐ No Tachycardia |
| Myocardial Infarction: ☐ Yes ☐ No | | |
| Poor Venous Circulation ☐ Yes ☐ No | ☐ Yes ☐ No Angina | ☐ Yes ☐ No Tachycardia |
| Poor Arterial Circulation ☐ Yes ☐ No | | |
| Has participant ever had major surgery or been hospitalized? ☐ Yes ☐ No | ☐ Yes ☐ No Menopause or Andropause (Male) | ☐ Yes ☐ No Tired Legs<br>☐ Yes ☐ No Swollen Ankles<br>☐ Yes ☐ No Varicose Veins<br>☐ Yes ☐ No Leg Ulcers |
| Please explain any significant operations, accidents or illnesses, and last medical attention and reason: | | ☐ Yes ☐ No Tingling<br>☐ Yes ☐ No Arthritis<br>☐ Yes ☐ No Back Pain<br>☐ Yes ☐ No Joint Pain<br>☐ Yes ☐ No Rheumatism<br>☐ Yes ☐ No Chronic Pain<br>☐ Yes ☐ No General Pain<br>☐ Yes ☐ No Muscular Pain<br>☐ Yes ☐ No Acne Scar<br>☐ Yes ☐ No Stretch Marks<br>☐ Yes ☐ No Surgical Scar<br>☐ Yes ☐ No Burn Scar<br>☐ Yes ☐ No Migraine<br>☐ Yes ☐ No Shingles |

| | |
|---|---|
| ☐ Yes | ☐ No Problem with Digestion |
| ☐ Yes | ☐ No Acid Indigestion |
| ☐ Yes | ☐ No Bloating |
| ☐ Yes | ☐ No Stomach or Duodenal Ulcer |
| ☐ Yes | ☐ No Rapid Weight gain or loss |
| ☐ Yes | ☐ No Overweight Problems |
| ☐ Yes | ☐ No Pancreas Problems |
| ☐ Yes | ☐ No Gall Stones/Gall Bladder |
| ☐ Yes | ☐ No Hepatitis |
| ☐ Yes | ☐ No Icterus (Juandice) |
| ☐ Yes | ☐ No Recurring Diarrhea |
| ☐ Yes | ☐ No Tuberculosis |
| ☐ Yes | ☐ No Asthma |
| ☐ Yes | ☐ No Chronic Bronchitis |
| ☐ Yes | ☐ No Emphysema |
| ☐ Yes | ☐ No Chronic Sinusitis |
| ☐ Yes | ☐ No Sinus Headaches |
| ☐ Yes | ☐ No Nervous Disturbances |
| ☐ Yes | ☐ No Depressions |
| ☐ Yes | ☐ No Loss of Memory |
| ☐ Yes | ☐ No Decreased Sexual Potency |
| ☐ Yes | ☐ No Sleep Disturbances |
| ☐ Yes | ☐ No Dizziness |
| ☐ Yes | ☐ No Chronic Migraine |
| ☐ Yes | ☐ N Reduced Vitality |
| ☐ Yes | ☐ No Thyroid Dysfunction |

**Reason for visit today:**

If you checked yes to any of the medical history questions, please explain:

**Patient Signature:** **Date:**