ROCOM
Division of Hoffmann-LaRoche Inc. Nutley, New Jersey 07110

Patient Data Base System

The ROCOM Patient Data Base System consists of two distinct but interrelated parts—a Health History Questionnaire and a Physical Examination Form. Together they provide the basic information required by the physician for your comprehensive health care. The Health History Questionnaire is for you to answer before the physician and his staff complete the Physical Examination Form. Please follow the directions given below, then return the completed Health History Questionnaire to the physician's office.
Note: Please do not remove the seals on either side of this form.

PATIENT INSTRUCTIONS

This health history questionnaire gives the physician information he needs about your health which only you can tell him.

The questionnaire is divided into sections. Please read the instructions given with each section before answering the questions. Please PRINT, using a ball-point pen, when you are asked to complete information. Make an (X) where you are asked to do so, pressing firmly on the pen. Spread the questionnaire out flat on a hard surface when filling it out. **Do not fold** or double it back on itself.

Take the time you need to finish the questionnaire. Do not worry about questions you cannot answer. If you are not sure how a question should be answered, place a solid circle ( ) in the "Yes" column or in the space provided if it is not a "Yes/No" question. You will have a chance to go over these questions with the aide when you return the form to the physician's office.

16 03 071 00
6/74

COLORITE 012456

NAME _____ AGE _____ Pt # _____

OCCUPATION _____ SOC SEC # _____

Height _ Weight ___ Build ___ (Sm. Med. Lg Obese) Pulse _ _ _ Resp ___ Temp. ___	**BLOOD PRESSURE** **Sitting** R / L / **Standing** R / L / **Lying** R / L /	**VISION** **Without Glasses** Far R 20/ L 20/ Near R / L / **With Glasses** R 20/ L 20/ R / L / **Tonometry** R ___ L ___ **Colorvision** _____ (Ishihara plates missed) **Peripheral Fields** R ___ L ___	**Diagnostic Tests** / **Results**

AUDIOMETRIC TESTING

	250	500	1000	2000	4000	8000
R						
L						

Gross Hearing _____

PULMONARY FUNCTION

Nurse's Signature

Problem Number	Data Base Summary/Initial Problem List	Plans

Employment status _____ Physician's signature _____

DATE _____

IDENTIFICATION DATA

Fill in the following information PLEASE PRINT

Date _____

Name _____ Date of birth _____ ____ Male ___ Female

Address _____ ___ Married ___ Separated ___ Divorced ___ Widowed ___ Single

Education ___ years Elementary ___ years High school

Home telephone _____ (area code) ___ years College, Technical Business etc

Business telephone _____ (area code) Occupation _____

FAMILY HISTORY

For your family members below, follow the line across the page and mark an X in those boxes which indicate their present state of health (good) (poor), or their death (write in the cause), and any of the illnesses that they have ever had

Print the names of your relatives living or dead in the spaces below

	Health																		
	Good	Poor	Died	Cause of death	Allergies or asthma	Anemia	Bleeding tendencies	Diabetes	Cancer or tumor	Epilepsy	Glaucoma	Gout	High blood pressure	Kidney or bladder trouble	Stomach / duodenal ulcer	Nervous breakdown	Rheumatism or arthritis	Heart trouble	
Father																			
Mother																			
Brothers or Sisters																			
Spouse																			
Children																			
Grandparents (Mark an X for illnesses only)																			
YOUR HEALTH HISTORY (begin here with illnesses →)																			

Additional Illnesses: Mark an X in the box next to any of the following illnesses you now or ever have had.

☐ eczema	☐ hemorrhoids	☐ thyroid disease	☐ mumps	☐ venereal disease
☐ hives or rashes	☐ hernia	☐ chicken pox	☐ nervous exhaustion	☐ yellow jaundice
☐ bronchitis	☐ liver disease	☐ German measles	☐ pneumonia	☐ other _____
☐ diverticulosis	☐ malaria	☐ scarlet fever	☐ polio	☐ _____
☐ emphysema	☐ neuralgia or neuritis	☐ measles	☐ kidney trouble	☐ _____
☐ eye infections	☐ pancreatitis	☐ mononucleosis	☐ rheumatic fever	☐ _____

Have you ever been turned down for life insurance, military service or employment because of health problems? ___ Yes ___ No

Major Hospitalizations: If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below. Check this box ☐ if you have had more than three such hospitalizations.

(Do not include normal pregnancies)

	Year	Operation or Illness	Name of Hospital	City and State
1st hospitalization				
2nd hospitalization				
3rd hospitalization				

Tests and Immunizations: Mark an X next to those which you have had. Enter the year when you last were given the test or "shots."

Year		Year	
☐ 19___	chest x-ray	☐ 19___	smallpox "shots"
☐ 19___	kidney x-ray	☐ 19___	tetanus "shots"
☐ 19___	G I series	☐ 19___	polio series
☐ 19___	colon x-ray	☐ 19___	typhoid "shots"
☐ 19___	gallbladder x-ray	☐ 19___	flu injections
☐ 19___	electrocardiogram	☐ 19___	mumps "shots"
☐ 19___	TB test	☐ 19___	measles "shots"
☐ 19___	other x-rays	☐ 19___	other _____

Medicines: Mark an X in the box next to any medicines that you are now taking or that you are allergic to

taking	allergic to		taking	allergic to	
☐	☐	aspirin	☐	☐	diet pills
☐	☐	penicillin	☐	☐	antacids
☐	☐	sulfa	☐	☐	laxatives
☐	☐	codeine	☐	☐	cold tablets
☐	☐	antibiotics	☐	☐	_____
☐	☐	sedatives	☐	☐	_____
☐	☐	stimulants	☐	☐	_____
☐	☐	Demerol	☐	☐	_____

Signature (if filled out by other than patient): _____

CONTINUE TO NEXT PAGE

COLORITE 012458

Please answer each of the following questions by placing an (X) in the "Yes" blank at the right if your answer to the questions is yes, or by placing an (X) in the "No" blank at the right if your answer to the question is no. If you are unable to answer for any reason, place a solid circle (●) in the "Yes" blank.

1 Are you troubled with stiff or painful muscles or joints?
2 Are your joints ever swollen?
3 Are you troubled by pains in the back or shoulder?
4 Are your feet often painful?
5 Are you handicapped in any way?

6 Do you have any skin problems?
7. Does your skin itch or burn?
8. Do you have trouble stopping even a small cut from bleeding?
9 Do you bruise easily?

10. Do you ever faint or feel faint?
11. Is any part of your body always numb?
12. Have you ever had fits or convulsions?
13. Has your handwriting changed lately?
14. Do you have a tendency to shake or tremble?

15. Are you very nervous around strangers?
16. Do you find it hard to make decisions?
17 Do you find it hard to concentrate or remember?
18. Do you usually feel lonely or depressed?
19. Do you often cry?
20. Would you say you have a hopeless outlook?
21. Do you have difficulty relaxing?
22. Do you have a tendency to worry a lot?
23. Are you troubled by frightening dreams or thoughts?
24. Do you have a tendency to be shy or sensitive?
25. Do you have a strong dislike for criticism?
26. Do you lose your temper often?
27. Do little things often annoy you?
28. Are you disturbed by any work or family problems?
29. Are you having any sexual difficulties?
30. Have you ever considered committing suicide?
31 Have you ever desired or sought psychiatric help?

32. Have you gained or lost much weight recently?
33. Do you have a tendency to be too hot or too cold?
34. Have you lost your interest in eating lately?
35. Do you always seem to be hungry?
36. Are you more thirsty than usual lately?
37. Are there any swellings in your armpits or groin?
38. Do you seem to feel exhausted or fatigued most of the time?
39. Do you have difficulty either falling or staying asleep?
40. Do you fail to get the exercise you should?
41. Do you smoke?
42 Do you take two or more alcoholic drinks a day?
43. Do you drink more than six cups of coffee or tea a day?
44. Have you ever used marijuana?
45. Have you ever used heroin, LSD or similar drugs?
46. Do you bite your nails?
47. Do you often ride in cars without using any safety belts?
48. List any country outside the United States you have visited in the past six months

TURN TO THE NEXT PAGE ➡

49 Are you troubled by heartburn?
50 Do you feel bloated after eating?
51 Are you troubled by belching?
52 Do you suffer discomfort in the pit of your stomach?
53 Do you easily become nauseated (feel like vomiting)?
54 Have you ever vomited blood?
55 Is it difficult or painful for you to swallow?
56 Are you constipated more than twice a month?
57 Are your bowel movements ever loose for more than one day?
58. Are your bowel movements ever black or bloody?
59 Are your bowel movements ever grey in color?
60 Do you suffer pains when you move your bowels?
61 Have you had any bleeding from your rectum?

62. Do you frequently get up at night to urinate?
63 Do you urinate more than five or six times a day?
64 Do you wet your pants or wet your bed?
65. Have you ever had burning or pains when you urinate?
66 Has your urine ever been brown, black or bloody?
67. Do you have any difficulty starting your urine flow?
68 Do you have a constant feeling that you have to urinate?

For Men Only

69 Is your urine stream very weak and slow?
70 Has a doctor ever told you that you have prostate trouble?
71. Have you had any burning or discharge from your penis?
72. Are there any swellings or lumps on your testicles?
73. Do your testicles get painful?

For Women Only

74. Are you having trouble with your menstrual periods?
75. Have you ever had bleeding between your periods?
76. Do you have heavy bleeding with your periods?
77. Do you ever have bleeding after intercourse?
78. Do you feel bloated and irritable before your period?
79. Do you have hot flashes?
80 Have you ever taken any birth control pills?
81 Have you ever had any lumps in your breasts?
82. Have you had any excessive discharges from your vagina?
83. Please print the month and year of your last PAP smear
84 Please print the date your last menstrual period began

Print the following information in the spaces at the right:

85. Number of pregnancies.
86. Number of miscarriages.
87 Number of stillbirths.
88. Number of premature births.
89. Number of children born alive.
90 Number of cesarean operations
91. Have you ever had an abortion?

TURN TO BACK OF THIS PAGE

Please print your name and today's date in the appropriate spaces at the right

92. Do you have headaches more than once a week?
93. Does twisting your neck quickly cause pain?
94 Have you ever had lumps or swelling in your neck?

95. Do you wear glasses?
96. Does your eyesight ever blur?
97 Is your eyesight getting worse?
98. Do you ever see double?
99 Do you ever see colored halos around lights?
100. Do you ever have pains or itching in or around your eyes?
101. Do your eyes blink or water most of the time?
102. Have you had any trouble with your eyes in the last two years?

103. Do you have difficulty hearing?
104. Have you had any earaches lately?
105. Have you been troubled by running ears lately?
106. Do you have a repeated buzzing or other noises in your ears?
107 Do you get motion sickness riding in a car or plane?

108. Do you have any problems with your teeth?
109. Do you have any sore swellings on your gums or jaws?
110. Is your tongue sore or sensitive?
111 Have your taste senses changed lately?

112. Is your nose stuffed up when you don't have a cold?
113. Does your nose run when you don't have a cold?
114 Do you ever have sneezing spells?
115. Do you ever have headcolds two or more months in a row?
116. Does your nose ever bleed for no reason at all?
117. Is your throat ever sore when you don't have a cold?
118. Has a doctor told you that your tonsils have been enlarged?
119. Has your voice ever been hoarse when you didn't have a cold?

120. Do you wheeze or have to gasp to breathe?
121. Are you bothered by coughing spells?
122. Do you cough up a lot of phlegm (thick spit)?
123. Have you ever coughed up blood?
124. Do you get chest colds more than once a month?
125. Are you sweating more than usual or have night sweats?

126. Have you ever been told that you had high blood pressure?
127. Have you been bothered by a thumping or racing heart?
128. Do you ever get pains or tightness in your chest?
129. Do you have trouble with dizziness or lightheadedness?
130. Does every little effort leave you short of breath?
131. Do you wake up at night short of breath?
132. Are you using more pillows to help you breathe at night?
133. Do you have trouble with swollen feet or ankles?
134. Are you getting cramps in your legs at night or upon walking?
135. Have you ever been told that you have a heart murmur?

Now, in the blank[illegible] at the right please write down any other problems or questions that you wish to discuss with the doctor.

END

Name _____ Date _____

92 Yes ___ No ___
93 Yes ___ No ___
94 Yes ___ No ___

95 Yes ___ No ___
96 Yes ___ No ___
97 Yes ___ No ___
98 Yes ___ No ___
99 Yes ___ No ___
100 Yes ___ No ___
101 Yes ___ No ___
102 Yes ___ No ___

103 Yes ___ No ___
104. Yes ___ No ___
105 Yes ___ No ___
106 Yes ___ No ___
107. Yes ___ No ___

108 Yes ___ No ___
109. Yes ___ No ___
110. Yes ___ No ___
111. Yes ___ No ___

112. Yes ___ No ___
113 Yes ___ No ___
114. Yes ___ No ___
115. Yes ___ No ___
116. Yes ___ No ___
117 Yes ___ No ___
118. Yes ___ No ___
119 Yes ___ No ___

120. Yes ___ No ___
121. Yes ___ No ___
122 Yes ___ No ___
123 Yes ___ No ___
124 Yes ___ No ___
125. Yes ___ No ___

126. Yes ___ No ___
127. Yes ___ No ___
128. Yes ___ No ___
129. Yes ___ No ___
130. Yes ___ No ___
131 Yes ___ No ___
132. Yes ___ No ___
133. Yes ___ No ___
134. Yes ___ No ___
135. Yes ___ No ___

49 Yes ___ No ___
50 Yes ___ No ___
51. Yes ___ No ___
52. Yes ___ No ___
53. Yes ___ No ___
54 Yes ___ No ___
55. Yes ___ No ___
56 Yes ___ No ___
57. Yes ___ No ___
58 Yes ___ No ___
59. Yes ___ No ___
60. Yes ___ No ___
61. Yes ___ No ___

62. Yes ___ No ___
63. Yes ___ No ___
64. Yes ___ No ___
65. Yes ___ No ___
66. Yes ___ No ___
67. Yes ___ No ___
68. Yes ___ No ___

60. Yes ___ No ___
70. Yes ___ No ___
71. Yes ___ No ___
72. Yes ___ No ___
73. Yes ___ No ___

74. Yes ___ No ___
75. Yes ___ No ___
76. Yes ___ No ___
77. Yes ___ No ___
78. Yes ___ No ___
79. Yes ___ No ___
80. Yes ___ No ___
81. Yes ___ No ___
82. Yes ___ No ___
83. _____
84. _____

85. _____
86. _____
87. _____
88. _____
89. _____
90. _____
91. Yes ___ No ___

1 Yes ___ No ___
2. Yes ___ No ___
3 Yes ___ No ___
4 Yes ___ No ___
5 Yes ___ No ___

6. Yes ___ No ___
7. Yes ___ No ___
8. Yes ___ No ___
9. Yes ___ No ___

10. Yes ___ No ___
11. Yes ___ No ___
12. Yes ___ No ___
13. Yes ___ No ___
14. Yes ___ No ___

15. Yes ___ No ___
16. Yes ___ No ___
17. Yes ___ No ___
18. Yes ___ No ___
19. Yes ___ No ___
20. Yes ___ No ___
21. Yes ___ No ___
22. Yes ___ No ___
23. Yes ___ No ___
24. Yes ___ No ___
25. Yes ___ No ___
26. Yes ___ No ___
27. Yes ___ No ___
28. Yes ___ No ___
29. Yes ___ No ___
30. Yes ___ No ___
31. Yes ___ No ___

32. Yes ___ No ___
33. Yes ___ No ___
34. Yes ___ No ___
35. Yes ___ No ___
36. Yes ___ No ___
37. Yes ___ No ___
38. Yes ___ No ___
39. Yes ___ No ___
40. Yes ___ No ___
41. Yes ___ No ___
42. Yes ___ No ___
43. Yes ___ No ___
44. Yes ___ No ___
45. Yes ___ No ___
46. Yes ___ No ___
47. Yes ___ No ___
48. _____

Special problems or symptoms: _____

Signature (if filled out by other than patient): _____

Name _____ Date _____ Patient no. _____

Doctor's notes _____

HEAD and NECK
- ____ frequent headaches
- ____ neck pains
- ____ neck lumps or swelling

EYES
- ____ wears glasses
- ____ blurry vision
- ____ eyesight worsening
- ____ sees double
- ____ sees halo
- ____ eye pains or itching
- ____ watering eyes
- ____ eye trouble

EARS
- ____ hearing difficulties
- ____ earaches
- ____ running ears
- ____ buzzing in ears
- ____ motion sickness

MOUTH
- ____ dental problems
- ____ swellings on gums or jaws
- ____ sore tongue
- ____ taste changes

NOSE and THROAT
- ____ congested nose
- ____ running nose
- ____ sneezing spells
- ____ headcolds
- ____ nose bleeds
- ____ sore throat
- ____ enlarged tonsils
- ____ hoarse voice

RESPIRATORY
- ____ wheezes or gasps
- ____ coughing spells
- ____ coughs up phlegm
- ____ coughed up blood
- ____ chest colds
- ____ excessive sweating, night sweats

CARDIOVASCULAR
- ____ high blood pressure
- ____ racing heart
- ____ chest pains
- ____ dizzy spells
- ____ shortness of breath
- ____ shortness of breath at night
- ____ more pillows to breathe
- ____ swollen feet or ankles
- ____ leg cramps
- ____ heart murmur

DIGESTIVE
- heartburn ____
- bloated stomach ____
- belching ____
- stomach pains ____
- nausea ____
- vomited blood ____
- difficulty swallowing ____
- constipation ____
- loose bowels ____
- black stools ____
- grey stools ____
- pain in rectum ____
- rectal bleeding ____

URINARY
- night frequency ____
- day frequency ____
- wets pants or bed ____
- burning on urination ____
- brown, black or bloody urine ____
- difficulty starting urine ____
- urgency ____

MALE GENITAL
- weak urine stream ____
- prostate trouble ____
- burning or discharge ____
- lumps on testicles ____
- painful testicles ____

FEMALE GENITAL
- menstrual trouble ____
- breakthrough bleeding ____
- heavy bleeding ____
- bleeding after intercourse ____
- premenstrual tension ____
- hot flashes ____
- birth control pill ____
- lumps in breasts ____
- vaginal discharge ____
- PAP smear _____
- last period _____

PREGNANCIES
- gravida _____
- miscarriages _____
- stillbirths _____
- premature births _____
- para _____
- cesareans _____
- abortion ____

MUSCULOSKELETAL
- ____ aching muscles or joints
- ____ swollen joints
- ____ back or shoulder pains
- ____ painful feet
- ____ handicapped

SKIN
- ____ skin problems
- ____ itching or burning skin
- ____ bleeds easily
- ____ bruises easily

NEUROLOGICAL
- ____ faintness
- ____ numbness
- ____ convulsions
- ____ change in handwriting
- ____ trembles

MOOD
- ____ nervous with strangers
- ____ difficulty in making decisions
- ____ lack of concentration or memory
- ____ lonely or depressed
- ____ cries often
- ____ hopeless outlook
- ____ difficulty relaxing
- ____ worries a lot
- ____ frightening dreams or thoughts
- ____ shy or sensitive
- ____ dislikes criticism
- ____ loses temper
- ____ annoyed by little things
- ____ work or family problems
- ____ sexual difficulties
- ____ considered suicide
- ____ desired psychiatric help

GENERAL
- ____ weight changes
- ____ tends to be hot or cold
- ____ loss of interest in eating
- ____ always hungry
- ____ more thirsty lately
- ____ armpits or groin swelling
- ____ fatigue
- ____ sleeping difficulties
- ____ lack of exercise
- ____ smokes
- ____ drinks alcohol daily
- ____ heavy coffee or tea drinker
- ____ marijuana
- ____ heroin, LSD, similar drugs
- ____ bites nails
- ____ doesn't use safety belts
- _____ visited in last 6 months

Special problems or symptoms: _____

Signature (if filled out by other than patient): _____

ROCOM Data Bas System PHYSICAL EXAMINATION

INSTRUCTIONS:
(WNL) Within Normal Limits
(POS) Positive findings (X) Omitted

GENERAL

a Posture
b Gait
c Speech
d Appearance
e Emotion

HEAD

a Hair
b Masses
c Shape
d Bruits
e Tenderness
f Sinus

EYES

a Lids R L
b Sclera R L
c Conjunctiva R L
d Muscles R L
e Cornea R L
f Pupils R L
g Fundi R L
h Light R L
i Bruit R L
j Accommodation R L

EARS

a Pinna R L
b Canal R L
c Drum R L
d Weber
e Rinne

NOSE

a Septum
b Mucosa R L
c Obstruction

MOUTH/THROAT

a Lips
b Breath
c Tongue
d Pharynx
e Tonsils
f Teeth
g Dentures
h Caries
i Larynx
j Floor
k Mucosa

NECK

a Thyroid
b Trachea
c Veins
d Spine
e Nodes R L
f Bruit R L
g Carotid R L
h Motion

LUNGS

a Chest
b Symmetry
c Diaphragm
d Rubs
e Bruit
f Sounds
g Fremitus

HEART

a PMI
b Rate
c Rhythm
d Thrill
e Tones
f Rub
g Murmurs

BREASTS

a Nodes R L
b Discharge R L
c Nipple R L
d Areolar R L
e Symmetry R L
f Consistency R L
g Scars R L

ABDOMEN

a Contour
b Tenderness
c Organs
d Masses
e Hernia R L
f Bruit R L
g Sounds R L
h Femoral Pulse R L
i Ing. Nodes R L

BACK

a Curvation
b Mobility
c Tenderness
CVA Renal
Bone

FEMALE GENITALS

a Labia
b Bartholin gland
c Urethra
d Vagina
e Cervix
f Uterus
g Adnexa R L
h Pap smear done
i Discharge

MALE GENITALS

a Penis
b Scrotum
c Testicles
d Discharge
e Scars
f Meatus
g Epididymis
h Varicocele

RECTAL

a Pilonidal
b Anus
c Sphincter
d Fissure
e Prostate
f Masses
g Hemorrhoids
h Sigmoid CM
i Mucosa
j Other

SKIN

a Scars
b Birthmarks
c Other marks
d Texture
e Sweat
f Color
g Ulcers

NEUROLOGICAL

	Strength*	Reflex**
a Biceps	R L	R L
b Triceps	R L	R L
c Knee	R L	R L
d Ankle	R L	R L
e Romberg		
f Babinsky		
g Cranial N		
h Sensory		
i Coordination		
j Tremor		
k Vibratory		

EXTREMITIES

a Color	R L	i Elbow	R L	p Leg	R L
b General	R L	j Radial P	R L	q Knee	R L
c Motion	R L	k Wrist	R L	r Ankle	R L
d Bruits	R L	l Hand	R L	s Foot	R L
e Edema	R L	m Fingers	R L	t Pedal P.	R L
f Varicosities	R L	n Nails	R L	u Toes	R L
g Shoulder	R L	o Hip	R L	v Nails	R L
h Arm	R L				

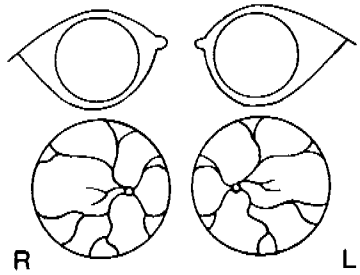
*When testing strength use grades Weak (W), Normal (N), Strong (S)
**When testing reflexes use Absent (A), Present (P), Brisk (B)

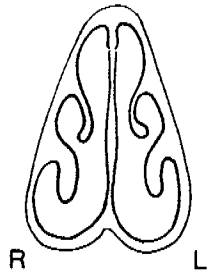
Signature

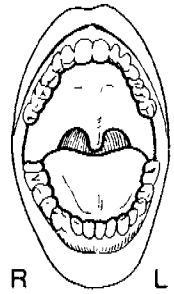
COLORITE 012464

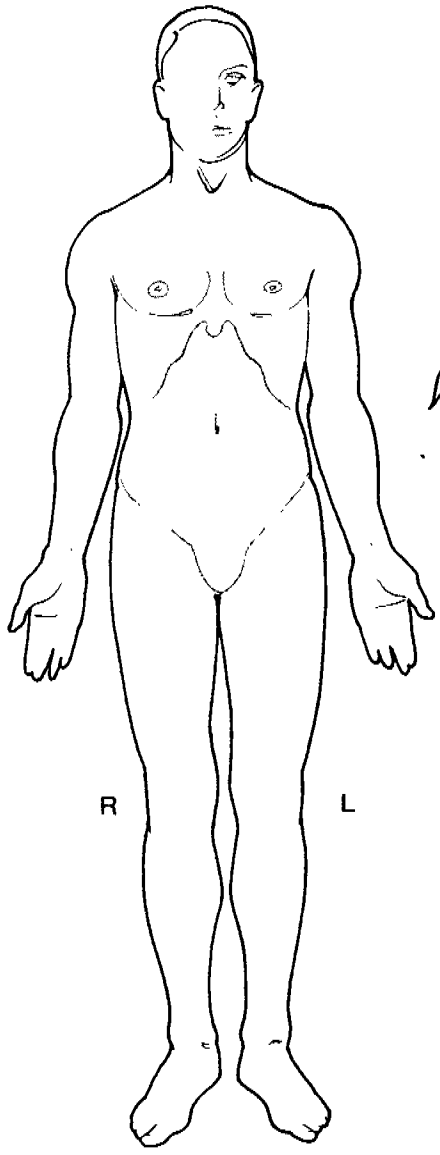
Patient name _____ Number _____

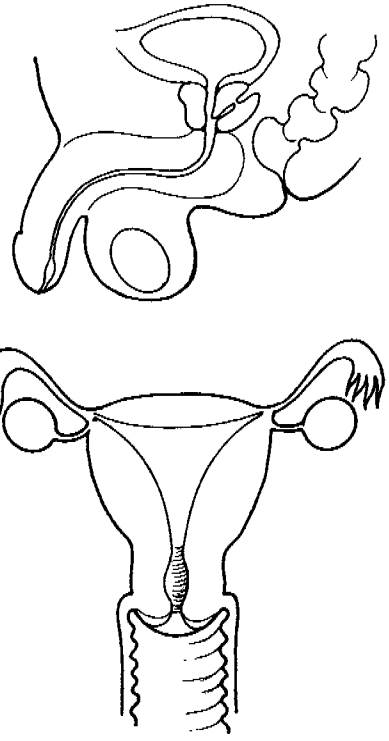
Date _____

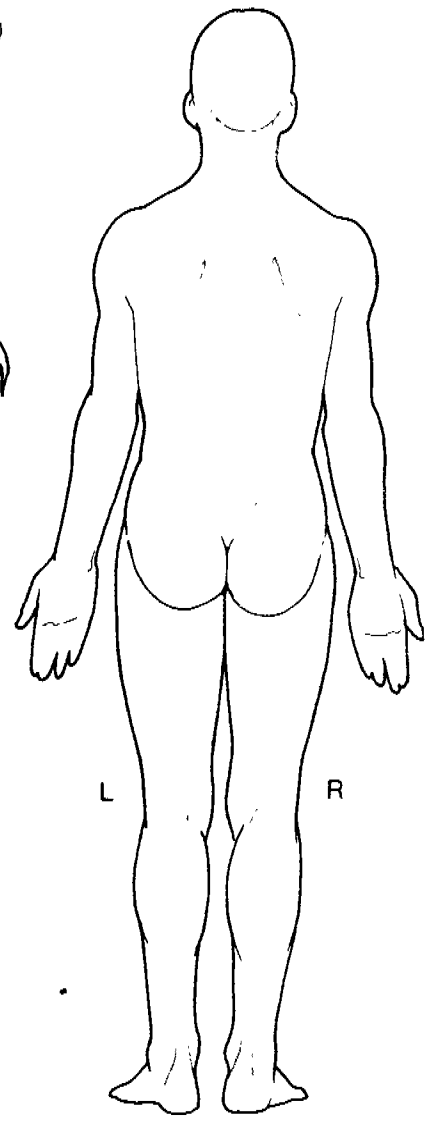


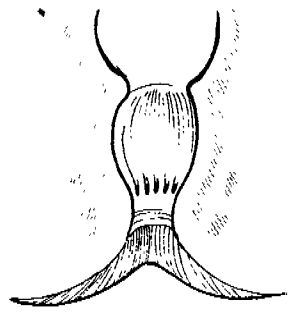












Signature _____

COLORITE 012465

Division of Hoffmann-LaRoche Inc., Nutley New Jersey 07110

Created and developed by Patient Care Systems, Inc.