

Patient Name: _____ Date of Birth: _____

Past hospitalizations, surgeries, injuries:	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Any complications after surgery? _____

Complications from anesthesia or sedation? _____

Present conditions requiring medical care:

Condition/How long?	Doctor	Last Visit
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Occupation: _____ Religion: _____

Do you or have you ever smoked? Yes No How long? _____

Number of packs daily: _____ When did you quit? _____

Do you or have you ever drunk alcohol? Yes No Type of alcohol: _____

How often? _____ How much? _____

Do you or have you ever used street drugs? Yes No What type/how often? _____

Exercise Routine/Type: _____ How often: _____

Marital status: Single Married Separated Divorced Widowed

Number of children: _____ Do you live alone? _____ Do you drive a car? _____

Significant Family History - List family members (parents, grandparents, brothers/sisters, children) who have had any of the following conditions:

Heart disease _____	Stroke _____
High Blood Pressure _____	Diabetes _____
Thyroid _____	Lung Disease _____
Cancer _____	Bleeding Disorder _____
Liver Disease _____	Gallbladder _____

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Check the conditions you have had in the past, or currently have.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> bleeding problems | <input type="checkbox"/> colon polyps | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> night sweats | <input type="checkbox"/> scarlet fever | <input type="checkbox"/> colitis | <input type="checkbox"/> broken bones |
| <input type="checkbox"/> unintended weight loss | <input type="checkbox"/> anemia | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> gout |
| <input type="checkbox"/> anorexia/bulimia/
eating disorder | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> diverticulosis (pockets in colon) | <input type="checkbox"/> artificial joints |
| <input type="checkbox"/> skin condition | <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> change in bowel habits | <input type="checkbox"/> chemical dependency |
| <input type="checkbox"/> skin cancer | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> frequent diarrhea | <input type="checkbox"/> nervousness/phobia |
| <input type="checkbox"/> skin rash | <input type="checkbox"/> leg swelling | <input type="checkbox"/> constipation | <input type="checkbox"/> depression/anxiety |
| <input type="checkbox"/> change in mole | <input type="checkbox"/> clot in leg/phlebitis | <input type="checkbox"/> black/bloody stools | <input type="checkbox"/> physical/sexual abuse |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> heart attack/MI | <input type="checkbox"/> leaking stool | |
| <input type="checkbox"/> frequent strep throat | <input type="checkbox"/> rheumatic fever | # of BM's daily _____ | |
| <input type="checkbox"/> voice changes | <input type="checkbox"/> previous stroke/TIA | <input type="checkbox"/> rectal pain | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> vision changes | <input type="checkbox"/> varicose veins | <input type="checkbox"/> swelling at rectum | <input type="checkbox"/> balance problems |
| <input type="checkbox"/> dizzy/fainting spells | <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> rectal protrusion | <input type="checkbox"/> numbness/tingling |
| <input type="checkbox"/> hearing changes | <input type="checkbox"/> heart murmur | <input type="checkbox"/> urine infections | <input type="checkbox"/> weakness |
| <input type="checkbox"/> frequent ear infections | <input type="checkbox"/> artificial heart valve/stent | <input type="checkbox"/> frequent urination | <input type="checkbox"/> seizures |
| <input type="checkbox"/> wheezing/asthma | <input type="checkbox"/> leg cramps when walking | <input type="checkbox"/> prostate problems | <input type="checkbox"/> trouble sleeping |
| <input type="checkbox"/> emphysema/COPD | <input type="checkbox"/> leg ulcers | <input type="checkbox"/> difficulty urinating | <input type="checkbox"/> frequent headaches |
| <input type="checkbox"/> change in phlegm/sputum | <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> urine leakage | <input type="checkbox"/> thyroid condition |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> blood in urine | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> frequent cough | <input type="checkbox"/> decreased appetite | <input type="checkbox"/> kidney stones | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> bronchitis/pneumonia | <input type="checkbox"/> stomach ulcer | <input type="checkbox"/> sexual preference | <input type="checkbox"/> blood transfusions |
| <input type="checkbox"/> coughing up blood | <input type="checkbox"/> hernia | _____ | <input type="checkbox"/> cancer |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> sexually transmitted disease | |
| <input type="checkbox"/> sleep apnea | <input type="checkbox"/> heartburn/reflux/indigestion | <input type="checkbox"/> menstrual irregularity | |
| | <input type="checkbox"/> jaundice | <input type="checkbox"/> menstrual pain/cramps | |
| | <input type="checkbox"/> hepatitis A B C | <input type="checkbox"/> post-menopausal | |
| | <input type="checkbox"/> gallbladder trouble | <input type="checkbox"/> vaginal tear at delivery | |

Notes: _____

Women Only

Number of: Pregnancies _____ Live births _____ Miscarriages _____ Abortions _____

Birth Control Method: _____ Last Menstrual period: _____

Date of last pap test and result: _____

Date of last mammogram and result: _____

Pediatric Patients Only (ages birth to 16 years)

Birth by: Vaginal delivery C-Section Any complications? Yes No

Born prematurely? Yes No If yes, how many weeks? _____

Vaccinations up to date? Yes No

The above information is true and correct to the best of my knowledge.

Patient's Signature: _____

Staff Signature: _____ **Date:** _____

Patient Name: _____ Date of Birth: _____

Physical Exam

Age _____ Height _____ Weight _____ Temp _____ Pulse _____ RR _____ BP _____

General: alert no distress _____

Skin: warm dry no lesion _____

HEENT: hearing & vision intact PER EOMI sclerae white pharynx clear
 mucosa moist _____

Neck: supple nl thyroid no nodes no JVD no bruit _____

Lungs: equal BS no rales no rhonchi no wheeze _____

Heart: RRR no murmur S1&S2 _____

Breast: no nipple retraction no dimpling no mass no discharge no adenopathy no skin changes

Abdomen: scaphoid BS+ nontender soft no mass no HSM no hernia
 no pulsation no bruit

Back: nontender _____

GU: nontender no testicular mass no hernia no discharge

Extremities: ambulatory nl ROM no edema no ulcers no clubbing no cyanosis
 nl CPR _____

Circulation:	radial	brachial	carotid	Femoral	popliteal	post tib	dors ped
Left							
Right							

Rectal: nl tone no mass nl prostate guaiac neg
Anoscopy _____ Proctoscopy _____ Flex. Sig. _____

Neuro: orientedx3 CN2-12 intact no gross deficit

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Labs:

X-Rays:

Impression:

Plan:

Entire form, including ROS, for today's exam has been reviewed by provider? Yes No

Patient is being seen in consultation at the request of _____
for _____. A letter is being sent to the
requesting physician.

Provider Signature: _____ Date: _____