

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 _____

Patient Name: _____ Date of Birth: _____

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

- | | | | |
|-----------------|-------------------|--------------|--------------|
| chronic fatigue | bleeding problems | colon polyps | arthritis |
| night sweats | scarlet fever | colitis | broken bones |

unintended weight loss
 anorexia/bulimia/
 eating disorder

skin condition
 skin cancer
 skin rash
 change in mole

sinus problems
 frequent strep throat
 voice changes
 vision changes
 dizzy/fainting spells
 hearing changes
 frequent ear infections

wheezing/asthma
 emphysema/COPD
 change in phlegm/sputum
 shortness of breath
 frequent cough
 bronchitis/pneumonia
 coughing up blood
 tuberculosis
 sleep apnea

anemia
 heart palpitations
 congestive heart failure
 high blood pressure
 leg swelling
 clot in leg/phlebitis
 heart attack/MI
 rheumatic fever
 previous stroke/TIA
 varicose veins
 chest pain/angina
 heart murmur
 artificial heart valve/stent
 leg cramps when walking
 leg ulcers

trouble swallowing
 nausea/vomiting
 decreased appetite
 stomach ulcer
 hernia
 abdominal pain
 heartburn/reflux/indigestion
 jaundice
 hepatitis A B C
 gallbladder trouble

Crohn's disease
 diverticulosis (pockets in colon)
 change in bowel habits
 frequent diarrhea
 constipation
 black/bloody stools
 leaking stool
 # of BM's daily _____
 rectal pain
 swelling at rectum
 rectal protrusion

urine infections
 frequent urination
 prostate problems
 difficulty urinating
 urine leakage
 blood in urine
 kidney stones
 sexual preference

 sexually transmitted disease
 menstrual irregularity
 menstrual pain/cramps
 post-menopausal
 vaginal tear at delivery

gout
 artificial joints

chemical dependency
 nervousness/phobia
 depression/anxiety
 physical/sexual abuse

memory loss
 balance problems
 numbness/tingling
 weakness
 seizures
 trouble sleeping
 frequent headaches

thyroid condition
 diabetes
 HIV/AIDS
 blood transfusions
 cancer

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

Patient Name: _____ Date of Birth: _____

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:** _____