

Patient History

Name _____ Male Female Date _____
 DOB _____ Age _____ Height _____ Weight _____
 Home phone _____ Primary care provider _____
 Work phone _____ Cell phone _____ Specialist _____

History of Present Illness

Chief Complaint: What is the main reason for your visit today? _____

Current Medications (prescribed by doctor)

Medication	Dosage Strength	When do you take medications(AM, PM, before meals)?

Medications NOT prescribed by doctor

(Herbal, vitamins, OTC-antihistamines, antacids, pain med, etc)

Medication	Medication

Allergies to medications Y N (if yes, list below with reaction) Latex Allergy? Y N

DRUG	REACTION

Surgical History

	Year		Year
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Joint	
<input type="checkbox"/> Heart bypass/valve		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Pacemaker/defibrillator		<input type="checkbox"/> Lungs	
<input type="checkbox"/> Gall bladder		<input type="checkbox"/> Other	
<input type="checkbox"/> Gastric bypass			

Have you ever had general anesthesia? Yes No
 Have you had any problems with anesthesia? Yes No If yes, please explain _____
 Is there a family history of anesthesia problems? Yes No If yes, please explain _____

Past Medical History

Cardiovascular History

Provider Comments

- | Yes | No | |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack (MI) |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure (HTN) |
| <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart valve problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart failure |
| <input type="checkbox"/> | <input type="checkbox"/> | Arterial blockage of the legs |
| <input type="checkbox"/> | <input type="checkbox"/> | Atrial fibrillation |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal EKG Where/when _____ |

Pulmonary

- | | | |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea/CPAP |
| <input type="checkbox"/> | <input type="checkbox"/> | COPD/Emphysema /chronic bronchitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Home Oxygen |

Neurological

- | | | |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | TIA (mini-stroke) |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder |

Digestive

- | | | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | GERD (heartburn/reflux) |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Cirrhosis |

Endocrine

- | | | |
|--------------------------|--------------------------|----------|
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |

Kidney

- | | | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease/dialysis |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems |

Musculoskeletal

- | | | |
|--------------------------|--------------------------|----------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis (if yes, please circle which type below) |
| | | Degenerative |
| | | Rheumatoid |
| | | Lupus |

Hematology/Cancer

- | | | |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots in legs or lungs |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| | | Type/ Year _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Transfusions |

Psychiatric

- | | | |
|--------------------------|--------------------------|------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |

Infectiousdisease

- | | | |
|--------------------------|--------------------------|-----------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | TB |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | MRSA |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes |

Social/Behavioral Health

- Do you smoke?
Packs per day _____ for _____ years
- Smoked in the past? Quit _____ years ago
- Do you drink alcohol? How much per day _____
- Do you use recreational drugs (marijuana, cocaine)?

Other medical conditions not listed above

- | | | |
|--------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any blood work, chest x-ray or EKG done in the past 6 months?
If yes, where was it done?
Primary care provider? _____
Specialist? _____
Hospitalization? _____ |

Family History

- Not known
- Father's age _____ or age at death _____, cause of death _____
- Mother's age _____ or age at death _____, cause of death _____
- How many brothers do you have living? _____ Deceased? _____
- How many sisters do you have living? _____ Deceased? _____

What medical conditions run in your family? Check each that applies.

	Father	Mother	Sibling(s)
Heart attack			
Angina			
Heart Failure			
Rhythm Problems			
Died Suddenly			
Stroke			
Diabetes			
High Blood Pressure			
High Cholesterol			
Cancer			

Review of Systems

Have you had any of the following in the past month?

General		Notes	Gastrointestinal		Notes
Yes	No	Weight Change	Yes	No	Poor Appetite
Yes	No	Fatigue	Yes	No	Abdominal Pain/Bloating
Yes	No	Fever	Yes	No	Heartburn
			Yes	No	Trouble Swallowing
Skin			Yes	No	Nausea/Vomiting
Yes	No	Change in moles	Yes	No	Diarrhea/Constipation
Yes	No	Rashes	Yes	No	Bloody/Black Stool
			Yes	No	Hemorrhoids
Eye/Ear/ Nose/Throat			Urinary Tract		
Yes	No	Vision Change	Yes	No	Bladder/Kidney infections
Yes	No	Hearing Loss	Yes	No	Painful Urination
Yes	No	Ear Ringing	Yes	No	Difficulty with Stream
Yes	No	Hay Fever/Sinus	Yes	No	Nighttime Urination
Yes	No	Hoarseness	Yes	No	Urine Leakage
Cardiovascular			Yes	No	Kidney Stones
Yes	No	Chest Pain	Muscle/Bone		
Yes	No	Irregular Heartbeat	Yes	No	Joint Pain/Swelling
Yes	No	Ankle Swelling	Yes	No	Gout
Yes	No	Heart Murmurs	Yes	No	Back Pain
Yes	No	Congestive Heart Failure	Yes	No	Osteoporosis/Fractures
Respiratory			Yes	No	Muscle Weakness/Pain
Yes	No	Shortness of Breath	Endocrine		
Yes	No	Cough	Yes	No	Hot/cold Intolerance
Yes	No	Wheezing	Yes	No	Hair growth or loss
Yes	No	Phlegm	Yes	No	High or low blood sugar
Blood/Lymph			Nervous System		
Yes	No	Anemia	Yes	No	Dizziness
Yes	No	Easy Bruising	Yes	No	Numbness/Tingling
Yes	No	Excessive Bleeding	Yes	No	Tremors
Yes	No	Blood Clots	Yes	No	Headache
			Yes	No	Depression/Anxiety
Female			Yes	No	Seizures
Yes	No	Breast lumps	Male		
Yes	No	Vaginal discharge	Yes	No	Testicular Lumps
Yes	No	Menstrual cramps/irregular periods	Yes	No	Prostate Problems
Last Menstrual period date:			Yes	No	

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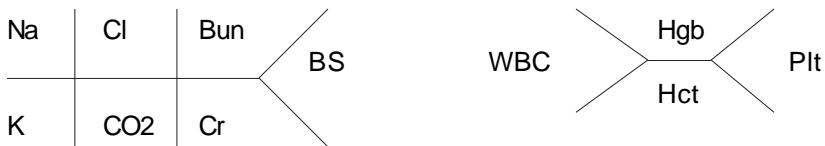
Patient Name _____ DOB _____

Physical Examination:

VS: T: _____ P: _____ R: _____ BP: _____ O2 Sat _____ % RA _____ LPM Wt _____ lbs/kg
 Ht _____ BMI _____

	Normal	Abnormal Findings
General		
HEENT		
Neck		
Heart		
Lungs		
Abdomen		
Extremities		
Neurological		
Skin		

Testing Results:



	Normal	Abnormal Findings
CXR		
UA		
EKG		
Other		

Assessment:

Recommendations:

Provider Signature _____ Date _____ Time _____