

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/Convulsion						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						

Hospitalization or Surgery

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? Yes No Planning pregnancy? Yes No

Medical History

Headache	Lactose intolerance	Depression
Shortness 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

Habits

Smoke: Packs daily _____ How long? _____ Interested in stopping? _____	Coffee: Cups daily _____ Other Caffeine _____ Alcohol: Type _____ Amount _____ Diet: Salt intake _____ Fat intake _____	Sleep: Difficulty falling asleep _____ Continuity disturbances _____ Snoring _____ Early morning awakening _____ Daytime drowsiness _____ Other _____
Exercise Routine: _____		

MEN ONLY: When you attempted sexual intercourse, was it satisfactory for you? Yes No
Do you have confidence in keeping your erection during intercourse? Yes No

Name _____ SS # _____ Date _____

Review of Systems

Neurologic	GI	Cardiovascular
GU	Cerebrovascular	Musculoskeletal.
Peripheral vascular	Dermatologic	Hematologic

Physical Exam

Temperature	Pulse	BP
Height	Weight	Respiration
General Appearance		

	N	AB	Notes
Skin			
HEENT			
Neck			
<i>Thyroid</i>			
<i>Lymph Nodes</i>			
<i>Veins/carotid</i>			
Chest			
Lungs			
Heart			
Abdomen			
Genital			
Rectal			
Extremities			
Joints			
Clubbing/cyanosis			
Peripheral pulses			
Edema			
Neurologic			

Tests Ordered

Chest X-ray	Barium enema	TB test.	Flexsigmoidoscopy
Kidney X-ray	Gallbladder	Air contrast: Obstruction series	ERCP
UGI series	Electrocardiogram	Endoscopy	Liver biopsy
Colonoscopy	Blood tests	ELISA	Elevated ALT

Impressions
