

HISTORY & PHYSICAL

DATE



NAME	<input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP	DATE OF BIRTH
ADDRESS	PHONE (H)		(O)	
OCCUPATION/ EMPLOYER	INSURANCE			

FAMILY HISTORY IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) Epilepsy	6) Thyroid disease	11) Osteoporosis	16) Lipid disorder
2) Migraine	7) Hay fever	12) Arthritis	17) Alcoholism
3) Mental illness	8) Asthma	13) Heart disease	18) Hepatitis
4) Glaucoma	9) Anemia	14) Stroke	19) Cancer
5) Diabetes	10) Bleeds easily	15) Hypertension	20)

HOSPITAL ADMISSIONS	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION
<i>not including pregnancies</i>				

LIST ALL MEDICATIONS YOU ARE NOW TAKING	ALLERGIES	VACCINE	YEAR OF LAST	TEST / EXAM	YEAR OF LAST
	SUPPLEMENTS	Tetanus / Td		Rectal / Stool	
		Influenza (flu)		Cholesterol	
		Pneumonia		Eye	
		Hepatitis		Dental	
		Tuberculosis			

MEDICAL HISTORY MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

MAIN PROBLEM

<input type="checkbox"/> Hearing problems <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Vision problems <input type="checkbox"/> Nose bleeds - recurrent <input type="checkbox"/> Sinus trouble <input type="checkbox"/> Sore throats - frequent <input type="checkbox"/> Hoarseness - prolonged <input type="checkbox"/> Hayfever / Allergies <input type="checkbox"/> Pneumonia / Pleurisy <input type="checkbox"/> Bronchitis / Chronic cough <input type="checkbox"/> Asthma / Wheezing <input type="checkbox"/> Shortness of breath: <input type="checkbox"/> on exertion <input type="checkbox"/> lying flat <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> Irregular pulse <input type="checkbox"/> Leg pain <input type="checkbox"/> Varicose veins / Phlebitis <input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Ringing in ear <input type="checkbox"/> Fainting spells <input type="checkbox"/> Eye pain <input type="checkbox"/> Abdominal pain- chronic <input type="checkbox"/> Jaundice / Hepatitis <input type="checkbox"/> Diarrhea <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Bloody or tarry stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Urination - Overactive Bladder <input type="checkbox"/> Overnight > than twice <input type="checkbox"/> More than 8 times / 24 hrs. <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> with leakage <input type="checkbox"/> Decrease in force/flow <input type="checkbox"/> Stress incontinence-urine leakage with exercise / movement <input type="checkbox"/> Blood in urine <input type="checkbox"/> Urine infections <input type="checkbox"/> Weight-loss - <input type="checkbox"/> gain <input type="checkbox"/> Height loss <input type="checkbox"/> Appetite <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer	<input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Gallbladder dis <input type="checkbox"/> Peptic ulcer <input type="checkbox"/> Constipation <input type="checkbox"/> Crohn's / Colitis <input type="checkbox"/> Hernia <input type="checkbox"/> Kidney stones <input type="checkbox"/> Prostate prob <input type="checkbox"/> Nutrition problems <input type="checkbox"/> Bruise easily <input type="checkbox"/> Easily fatigued
<input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Tremor / hands shaking <input type="checkbox"/> Numbness / tingling sensations <input type="checkbox"/> Headaches - frequent <input type="checkbox"/> Arthritis / Rheumatism <input type="checkbox"/> Back pain - recurrent <input type="checkbox"/> Bone fracture / joint injury <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Rashes <input type="checkbox"/> Psoriasis <input type="checkbox"/> Concentration prob <input type="checkbox"/> Depression <input type="checkbox"/> Moodiness <input type="checkbox"/> Memory loss <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes <input type="checkbox"/> Sexual problems / enjoyment	<input type="checkbox"/> Thyroid disease <input type="checkbox"/> Stroke <input type="checkbox"/> Gout <input type="checkbox"/> Hives <input type="checkbox"/> Eczema <input type="checkbox"/> Sleep problems <input type="checkbox"/> Nervousness <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Mental illness <input type="checkbox"/> Measles <input type="checkbox"/> Polio <input type="checkbox"/> Mumps <input type="checkbox"/> German measles <input type="checkbox"/> Aids / HIV <input type="checkbox"/> STD	<input type="checkbox"/> Decreased life enjoyment <input type="checkbox"/> Decreased work performance <input type="checkbox"/> Alcohol _____ oz. per week <input type="checkbox"/> Coffee / Tea _____ cups per day <input type="checkbox"/> Smoking- cig/day _____ # years year quit _____ <input type="checkbox"/> Exercise _____ <input type="checkbox"/> Street Drugs _____ FEMALES - Please complete Menstrual flow: <input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain / Cramps Days of flow _____ Length of cycle _____ Date -1st day of last period _____ <input type="checkbox"/> Pain / Bleeding during or after sex Number of: Pregnancies _____ Abortions _____ Miscarriages _____ Live births _____ Birth control method _____ <input type="checkbox"/> Flushing / Menopause Date of last PAP test _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Date of last mammogram _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

SYNOPSIS

PHYSICAL EXAM



VITAL SIGNS		HT	WT	BMI	BP SUPINE	BP SITTING	PULSE	RESP RATE	TEMP							
VISION	DISTANT (UNCORR)	(R)	(L)	DISTANT (CORR)	(R)	(L)	NEAR (UNCORR)	(R)	(L)	NEAR (CORR)	(R)	(L)	COLOUR VISION	TONO METRY	(R)	(L)
OFFICE TESTS		URINALYSIS -										MICRO				
Hgb		STOOL O.B.	COLOR	S.GR	pH	PROT	GLUC	KETO	BILI	BLOOD	NITRITE	UROB				
COMMENTS																
GENERAL APPEARANCE																

PHYSICAL EXAM		POSITIVE/ABNORMAL	NEGATIVE/NORMAL	<input checked="" type="checkbox"/> POSITIVE OR ABNORMAL FINDINGS	POSITIVE/ABNORMAL	NEGATIVE/NORMAL	POSITIVE/ABNORMAL	NEGATIVE/NORMAL
HEAD & NECK	Head, Scalp	<input type="checkbox"/>	<input type="checkbox"/>		Hernial Rings	<input type="checkbox"/>	<input type="checkbox"/>	
	Lids-Sclera-Conj.	<input type="checkbox"/>	<input type="checkbox"/>		Inguinal Nodes	<input type="checkbox"/>	<input type="checkbox"/>	
	Eye Muscles	<input type="checkbox"/>	<input type="checkbox"/>		Pulses -Femoral	<input type="checkbox"/>	<input type="checkbox"/>	
	Pupils	<input type="checkbox"/>	<input type="checkbox"/>		Popliteal	<input type="checkbox"/>	<input type="checkbox"/>	
	Fundi	<input type="checkbox"/>	<input type="checkbox"/>		Post Tibial	<input type="checkbox"/>	<input type="checkbox"/>	
	Ears	<input type="checkbox"/>	<input type="checkbox"/>		Dorsalis Pedis	<input type="checkbox"/>	<input type="checkbox"/>	
	Nose / Sinuses	<input type="checkbox"/>	<input type="checkbox"/>		V. Veins <input type="checkbox"/> Edema <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Teeth / Gums	<input type="checkbox"/>	<input type="checkbox"/>		Cyanosis <input type="checkbox"/> Clubbing <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Pharynx	<input type="checkbox"/>	<input type="checkbox"/>		&- Vulva / Vagina	<input type="checkbox"/>	<input type="checkbox"/>	
	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>		Adnexae	<input type="checkbox"/>	<input type="checkbox"/>	
CHEST	Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>		Cervix	<input type="checkbox"/>	<input type="checkbox"/>	
	Carotid Bruits	<input type="checkbox"/>	<input type="checkbox"/>		Uterus	<input type="checkbox"/>	<input type="checkbox"/>	
	Chest-Lungs	<input type="checkbox"/>	<input type="checkbox"/>		Utero / Rectocoele	<input type="checkbox"/>	<input type="checkbox"/>	
	Heart-Apex (location)				Pap Test (done) ^{YES NO} <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Heart Sound	<input type="checkbox"/>	<input type="checkbox"/>		Genitalia - (male)	<input type="checkbox"/>	<input type="checkbox"/>	
ABDOMEN	Murmurs / Thrills	<input type="checkbox"/>	<input type="checkbox"/>		- Prostate	<input type="checkbox"/>	<input type="checkbox"/>	
	Breasts & Nipples	<input type="checkbox"/>	<input type="checkbox"/>		Ano-Rectal	<input type="checkbox"/>	<input type="checkbox"/>	
	Axillary Nodes	<input type="checkbox"/>	<input type="checkbox"/>		Sigmoidoscopy			
	Abdominal Masses	<input type="checkbox"/>	<input type="checkbox"/>		Skin Lesions	<input type="checkbox"/>	<input type="checkbox"/>	
	Abdominal Tend	<input type="checkbox"/>	<input type="checkbox"/>		Nail Beds - Fingers	<input type="checkbox"/>	<input type="checkbox"/>	
DERM	Liver /Spleen	<input type="checkbox"/>	<input type="checkbox"/>		- Toes	<input type="checkbox"/>	<input type="checkbox"/>	
	Abdominal Bruits	<input type="checkbox"/>	<input type="checkbox"/>					
INVESTIG	<input type="checkbox"/> CBC				<input type="checkbox"/> CHEST X-RAY			<input type="checkbox"/> MAMMOGRAM
					<input type="checkbox"/> ECG			
	<input type="checkbox"/> PSA							
	<input type="checkbox"/> TESTOSTERONE							

SYNOPSIS		PLANS	