



HISTORY AND PHYSICAL

APPOINTMENT DATE: _____

PATIENT	NAME-LAST	FIRST	M.I.	DATE OF BIRTH	AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NO.	
	HOME ADDRESS	CITY	STATE	ZIP CODE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED			
	PREFERRED PHONE NUMBER TO BE CONTACTED							
	IN CASE OF EMERGENCY CONTACT NAME		EMERGENCY CONTACT PHONE			RELATIONSHIP		
	PRIMARY CARE PHYSICIAN					DATE OF LAST VISIT		
	EMPLOYER/OCCUPATION							
	PREFERRED PHARMACY AND PHONE NUMBER							

INSURANCE	WHO SHOULD WE THANK FOR YOUR REFFERAL	REFERRING PHONE NUMBER (IF APPLICABLE)
	INSURANCE COMPANY	EMPLOYER OF INSURED
	ID OR POLICY NUMBER	POLICY HOLDER OR INSURED NAME
	GROUP NUMBER	PRE-CERTIFICATION PHONE NUMBER

PRESENT ILLNESS INFORMATION	SYMPTOMS OR REASON FOR VISIT	CURRENT SEVERITY OF PROBLEM	PREVIOUS TREATMENTS FOR PROBLEM (MEDS OR SURGERY, ETC.)
	1)	PLEASE RATE YOUR CONDITION ON A SCALE OF 1-10 WITH 1 BEING NORMAL LIFESTYLE AND 10 BEING SEVERE EFFECTS ON LIFESTYLE 1 2 3 4 5 6 7 8 9 10	
	2)		
	3)	WHEN DID YOU FIRST NOTICE THE PROBLEM?	HOW OFTEN DO YOU HAVE THESE PROBLEMS?
	4)	FAMILY HISTORY OF SIMILAR PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO	
	WHAT IS THE MEDICAL PROBLEM YOU NEED ADDRESSED TODAY?		
DOES ANYTHING MAKE YOUR PROBLEM WORSE OR BETTER?			
HAVE YOU BEEN EVALUATED FOR THIS PROBLEM BEFORE (WHAT WAS THE DIAGNOSIS GIVEN?)			

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ALLERGIES	PLEASE LIST ALLERGIES (MEDICATIONS OR FOODS)		TYPE OF REACTION (RASH, DIFFICULTY BREATHING, ETC.)	
MEDICATIONS	PLEASE LIST ALL MEDICATIONS (INCLUDING OVER THE COUNTER, VITAMINS AND HERBALS)		STRENGTH AND FREQUENCY	
IMPLANTS	PLEASE LIST ALL IMPLANTS (PENILE, BREAST, PACER, ETC.)			

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PLEASE CHECK YES IF YOU HAVE EVER HAD ANY OF THE FOLLOWING CONDITIONS				
PAST MEDICAL HISTORY/ CURRENT ILLNESSES	ANEMIA	YES <input type="checkbox"/> NO <input type="checkbox"/>	IRREGULAR HEARTBEAT	YES <input type="checkbox"/> NO <input type="checkbox"/>
	ASTHMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	HIGH CHOLESTEROL	YES <input type="checkbox"/> NO <input type="checkbox"/>
	ARTHRITIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	JAUNDICE	YES <input type="checkbox"/> NO <input type="checkbox"/>
	BLADDER DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>	KIDNEY FAILURE	YES <input type="checkbox"/> NO <input type="checkbox"/>
	BLEEDING TENDENCIES	YES <input type="checkbox"/> NO <input type="checkbox"/>	KIDNEY STONES	YES <input type="checkbox"/> NO <input type="checkbox"/>
	BRONCHITIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	MEASLES	YES <input type="checkbox"/> NO <input type="checkbox"/>
	CANCER	YES <input type="checkbox"/> NO <input type="checkbox"/>	MENTAL ILLNESS	YES <input type="checkbox"/> NO <input type="checkbox"/>
	CATARACTS	YES <input type="checkbox"/> NO <input type="checkbox"/>	MUMPS	YES <input type="checkbox"/> NO <input type="checkbox"/>
	CHICKEN POX	YES <input type="checkbox"/> NO <input type="checkbox"/>	POLIOMYELITIS	YES <input type="checkbox"/> NO <input type="checkbox"/>
	DEMENTIA (MEMORY PROBLEMS)	YES <input type="checkbox"/> NO <input type="checkbox"/>	RHEUMATIC FEVER	YES <input type="checkbox"/> NO <input type="checkbox"/>
	DIABETES MELLITUS	YES <input type="checkbox"/> NO <input type="checkbox"/>	SCARLET FEVER	YES <input type="checkbox"/> NO <input type="checkbox"/>
	EMPHYSEMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>
	GALLBLADDER DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>	SEIZURES	YES <input type="checkbox"/> NO <input type="checkbox"/>
	GASTRO-ESOPHAGEAL REFLUX DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>	SKIN LESIONS / SEVERE RASH	YES <input type="checkbox"/> NO <input type="checkbox"/>
	GLAUCOMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	SICKLE CELL DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>
	HEARING LOSS	YES <input type="checkbox"/> NO <input type="checkbox"/>	STROKE	YES <input type="checkbox"/> NO <input type="checkbox"/>
	HEART DISEASE / HEART ATTACK	YES <input type="checkbox"/> NO <input type="checkbox"/>	THYROID DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>
	HEPATITIS: __A__B__C	YES <input type="checkbox"/> NO <input type="checkbox"/>	TUBERCULOSIS	YES <input type="checkbox"/> NO <input type="checkbox"/>
HIGH BLOOD PRESSURE	YES <input type="checkbox"/> NO <input type="checkbox"/>	OTHER MEDICAL CONDITIONS		
HIV / AIDS	YES <input type="checkbox"/> NO <input type="checkbox"/>			
HOSPITALIZATIONS	PLEASE LIST MAJOR HOSPITALIZATIONS AND SURGERIES			YEAR

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SOCIAL HISTORY	LEVEL OF EDUCATION:			
	HIGH SCHOOL <input type="checkbox"/> COLLEGE <input type="checkbox"/> GRADUATE SCHOOL <input type="checkbox"/>			
	OCCUPATION			
	PLEASE LIST ALL EXPOSURES TO TOXIC CHEMICALS OR GASES			
	LIVES WITH		HOBBIES	
	TRAVEL HISTORY (PLEASE LIST TRAVEL TO FOREIGN COUNTRIES OVER THE PAST 3 YEARS)			
	TOBACCO (CIGARETTES, SNUFF, CHEWING, PIPES, CIGARS)	RECENT YES <input type="checkbox"/> NO <input type="checkbox"/>	PAST YES <input type="checkbox"/> NO <input type="checkbox"/>	AMOUNT
	ALCOHOL	RECENT YES <input type="checkbox"/> NO <input type="checkbox"/>	PAST YES <input type="checkbox"/> NO <input type="checkbox"/>	AMOUNT
ILLCIT DRUGS	RECENT YES <input type="checkbox"/> NO <input type="checkbox"/>	PAST YES <input type="checkbox"/> NO <input type="checkbox"/>	TYPE OF DRUGS	
EXERCISE	RECENT YES <input type="checkbox"/> NO <input type="checkbox"/>	PAST YES <input type="checkbox"/> NO <input type="checkbox"/>	AMOUNT	



FAMILY MEDICAL HISTORY	PLEASE ANSWER QUESTIONS REGARDING <u>FAMILY</u> MEDICAL HISTORY			
	MOTHER'S AGE (OR AGE AT DEATH) AND MEDICAL PROBLEMS (IF NOT LISTED BELOW)			ALIVE YES <input type="checkbox"/> NO <input type="checkbox"/>
	FATHER'S AGE (OR AGE AT DEATH) AND MEDICAL PROBLEMS (IF NOT LISTED BELOW)			ALIVE YES <input type="checkbox"/> NO <input type="checkbox"/>
	ALZHEIMER'S DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>	HEART PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>
	ASTHMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	HEARING LOSS	YES <input type="checkbox"/> NO <input type="checkbox"/>
	ARTHRITIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	KIDNEY DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>
	CANCER	YES <input type="checkbox"/> NO <input type="checkbox"/>	THYROID DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>
	CATARACTS	YES <input type="checkbox"/> NO <input type="checkbox"/>	HIGH BLOOD PRESSURE	YES <input type="checkbox"/> NO <input type="checkbox"/>
	DIABETES	YES <input type="checkbox"/> NO <input type="checkbox"/>	OTHER MAJOR FAMILY MEDICAL PROBLEMS	
	EPILEPSY	YES <input type="checkbox"/> NO <input type="checkbox"/>		

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**PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS
YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS**

REVIEW OF SYSTEMS	GENERAL	EASILY FATIGUED	FATIGUED ONLY AFTER EXERCISE	FATIGUED UPON WAKING	EXCESSIVE WEIGHT GAIN	EXCESSIVE WEIGHT LOSS	NIGHT SWEATS	FEVER
	BLOOD	ANEMIA (LOW BLOOD COUNT)	BLEEDING DISORDERS	TAKING COUMADIN	EASY CLOTTING	BLOOD CLOT	DVT	
	SKIN	BLEEDING	EASILY BRUISING	SORES	ITCHING	SCALING	VARICOSE VEINS	NON HEALING LEG / FOOT WOUNDS
	GLANDS	ENLARGEMENT	PAIN	DRAINAGE	LYMPHOMA			
	EYES	GLASSES	CATARACTS	TRAUMA	INFECTION	TEMPORARY BLINDNESS	VISUAL LOSS	GLAUCOMA
	EAR	INFECTION	LOSS OF HEARING	PAIN	RINGING IN THE EARS	RUPTURED EAR DRUM		
	NOSE	SINUS INFECTION	NOSE BLEEDS	RUNNY NOSE				
	MOUTH /THROAT	DIFFICULTY CHEWING	EXCESSIVE TONGUE MOVEMENT	PAIN	DENTURES	FREQUENT SORE THROAT	HOARSENESS	PAIN OR DIFFICULTY SWALLOWING
	NECK	LIMITATION OF MOVEMENT	PAIN	STIFFNESS	TRAUMA	WEAKNESS	SWELLING	
	RESPIRATORY	ASTHMA	COUGHING	LUNG INFECTIONS	COUGHING UP MUCUS	COUGHING UP BLOOD	SHORTNESS OF BREATH AT REST	SHORTNESS OF BREATH AFTER EXERTION
	HEART / CV	IRREGULAR HEART BEAT	CHEST PAIN	COLD HAND AND / OR FEET	PAIN IN LEGS AFTER WALKING	PALPITATIONS	SHORTNESS OF BREATH	SWELLING OF HANDS AND/OR FEET
	GI	NAUSEA	INDIGESTION	VOMITING	ABDOMEN PAIN	VOMITING BLOOD	JAUNDICE (YELLOW SKIN)	BLOOD IN STOOL
	GENITOURINARY	CHANGE IN COLOR OF URINE	DECREASED URINATION	PAINFUL URINATION	FREQUENT URINATION AT NIGHT	INCREASED URINATION	CHANGE IN MENSTRUAL CYCLE	ERECTILE DYSFUNCTION / IMPOTENCE
	SKELETAL	GENERALIZED WEAKNESS OF MUSCLES	MUSCLE PARALYSIS	DECREASE IN MUSCLE SIZE	DECREASE IN MUSCLE STRENGTH	INVOLUNTARY MOVEMENT	ARTHRITIS	JOINT PAIN
	NEUROLOGICAL	DIZZINESS	FALLS / BALANCE DIFFICULTY	SLURRED SPEECH	SEVERE HEADACHES	SEIZURE	BURNING PAIN / NUMBNESS / TINGLING	LOW BACK PAIN
PSYCHIATRIC	MEMORY LOSS	DIFFICULTY FOCUSING	DEPRESSION	MOOD SWINGS	SLEEP DISTURBANCE	BLACK OUTS	LIGHT HEADEDNESS	

THE FOLLOWING QUESTIONNAIRE IS INTENDED TO HELP US BETTER EVALUATE AND TREAT YOUR MEDICAL PROBLEMS. WE APPRECIATE YOU FILLING IT OUT IN ITS ENTIRETY. SHOULD YOU HAVE ANY QUESTIONS ABOUT WHAT INFORMATION TO INCLUDE DON'T HESITATE TO ASK THE OFFICE STAFF.

SIGNATURES	PATIENT SIGNATURE	DATE
	PHYSICIAN SIGNATURE	DATE

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PHYSICIAN USE ONLY BELOW

PHYSICAL EXAMINATION	PROBLEM FOCUSED 1-5, EXPANDED PROBLEM FOCUSED 6, DETAILED 12, COMPREHENSIVE ALL SHADED PLUS 1 UNSHADED					
	HEIGHT *	WEIGHT *	BP *	TEMP *	PULSE *	RESP *
	CONSTITUTIONAL *	NORMAL	WD	WN		
	HEENT *	NORMAL	EOMI	JVD	SUPPLE	BRUIT MP SCORE
	RESPIRATORY *	NORMAL	CTA	TRACH MIDLINE	RESP EFF	
	CARDIOVASCULAR *	NORMAL	MURMUR	RUB	BRUIT	EDEMA PULSES
	ABDOMEN *	NORMAL	BS	MASSES	TENDERNESS	
	PELVIC / RECTAL	NORMAL	DEFFERED			
	SKIN	NORMAL	CLUBBBING	CYANOSIS	RASH	LESION VARICOSITIES
	MS	NORMAL	GAIT	UNSTEAD	WEAKNESS	
	NEUROLOGICAL	NORMAL	STRENGTH	GRIP	CN II-XII	
	PSYCHIATRIC	NORMAL	ORIENTATION	MS	MOOD	AFFECT
	OTHER FINDINGS					

ASSESSMENT / PLAN	TESTS					
	ASSESSMENT					
	PLAN					
						<input type="checkbox"/> I HAVE DISCUSSED THE RISK, BENEFITS, OPTIONS AND ALTERNATIVES WITH THE PATIENT
	FOLLOW UP		DAYS	WEEKS	MONTHS	PRN
	PHYSICIAN SIGNATURE				TOTAL TIME	DATE

CODING	HPI	HISTORY	REVIEW OF SYSTEMS	PHYSICAL EXAMINATION	TYPE	C
	BRIEF 1-3	N/A	N/A	1-5 ELEMENTS	PROBLEM FOCUSED	
	BRIEF 1-3	N/A	PERTINENT PROBLEM 1	AT LEAST 6 ELEMENTS	EXPANDED	
	EXTENDED >4	PERTINENT 1	EXTENDED 2-9	AT LEAST 12 ELEMENTS	DETAILED	
	EXTENDED >4	COMPLETE 3	COMPLETE >= 10	ALL SHADED * & 1 UNSHADED	COMPREHENSIVE	