

HISTORY & PHYSICAL

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	DATE
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	11) OSTEOPOROSIS	16) ALCOHOLISM
2) MIGRAINE	7) HAYFEVER	12) ARTHRITIS	17) CANCER
3) MENTAL ILL.	8) ASTHMA	13) HEART DISEASE	18)
4) GLAUCOMA	9) ANEMIA	14) STROKE	19)
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
		TETANUS / Td FLU PNEUMONIA HEPATITIS TUBERCULOSIS		RECTAL / STOOL CHOLESTEROL EYE	

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

MAIN PROBLEMS 1) _____ 2) _____ 3) _____

<input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Ringing in Ear <input type="checkbox"/> Ear Infections - frequent <input type="checkbox"/> Dizzy Spells <input type="checkbox"/> Failing Vision <input type="checkbox"/> Eye Pain <input type="checkbox"/> Double or Blurred Vision <input type="checkbox"/> Eye Infections - frequent <input type="checkbox"/> Nose Bleeds - recurrent <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Sore Throats - frequent <input type="checkbox"/> Hayfever / Allergies <input type="checkbox"/> Hoarseness - prolonged <input type="checkbox"/> Pneumonia / Pleurisy <input type="checkbox"/> Bronchitis / Chronic Cough <input type="checkbox"/> Asthma / Wheezing 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"/> Palpitations <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Leg Pain - walking <input type="checkbox"/> Varicose Veins / Phlebitis	<input type="checkbox"/> Loss of Appetite - recent <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Indigestion or Heartburn <input type="checkbox"/> Persistent Nausea / Vomiting <input type="checkbox"/> Peptic Ulcers <input type="checkbox"/> Abdominal Pain - chronic <input type="checkbox"/> Gall Bladder Trouble <input type="checkbox"/> Jaundice / Hepatitis <input type="checkbox"/> Change in Bowel Habits: <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's / Colitis <input type="checkbox"/> Bloody or Tarry Stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia <input type="checkbox"/> Urine Infections - frequent <input type="checkbox"/> Blood in Urine Urination - <input type="checkbox"/> Overnight, > than twice <input type="checkbox"/> Painful <input type="checkbox"/> Loss of Control <input type="checkbox"/> Decrease in Force / Flow <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Urethral Discharge <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Weight Loss - recent <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Convulsions / Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tremor / Hands Shaking <input type="checkbox"/> Muscle Weakness <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"/> Gout <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Foot Pain <input type="checkbox"/> Cold Numb Feet <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Sleeping - difficulty <input type="checkbox"/> Nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Memory Loss <input type="checkbox"/> Moodiness - excessive <input type="checkbox"/> Phobias <input type="checkbox"/> Mental Illness	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes <input type="checkbox"/> Contact with Blood or Body Fluids <input type="checkbox"/> Alcohol oz. per week <input type="checkbox"/> Smoking cig. per day #yrs. <input type="checkbox"/> Coffee / Tea cups per day 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 _____ B.C. Pill (name) _____ <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
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SYNOPSIS

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

PHYSICAL EXAM		NEG. NORM.	DEFECT			NEG. NORM.	DEFECT			NEG. NORM.	DEFECT			
H E A D & N E C K	Head, Scalp	<input type="checkbox"/>	<input type="checkbox"/>	E X T R E M I T I E S	Hernial Rings	<input type="checkbox"/>	<input type="checkbox"/>	J O I N T S	Neck	<input type="checkbox"/>	<input type="checkbox"/>			
	Lids-Sclera-Conj.	<input type="checkbox"/>	<input type="checkbox"/>		Inguinal Nodes	<input type="checkbox"/>	<input type="checkbox"/>		Shoulders	<input type="checkbox"/>	<input type="checkbox"/>			
	Eye Muscles	<input type="checkbox"/>	<input type="checkbox"/>		Pulses - Femoral	ST <input type="checkbox"/>	WK <input type="checkbox"/>		AB <input type="checkbox"/>	Elbows	<input type="checkbox"/>	<input type="checkbox"/>		
	Pupils	<input type="checkbox"/>	<input type="checkbox"/>		Popliteal	ST <input type="checkbox"/>	WK <input type="checkbox"/>		AB <input type="checkbox"/>	Wrists	<input type="checkbox"/>	<input type="checkbox"/>		
	Fundi	<input type="checkbox"/>	<input type="checkbox"/>		Post Tibial	ST <input type="checkbox"/>	WK <input type="checkbox"/>		AB <input type="checkbox"/>	Fingers	<input type="checkbox"/>	<input type="checkbox"/>		
	Ears	<input type="checkbox"/>	<input type="checkbox"/>		Dorsalis Pedis	ST <input type="checkbox"/>	WK <input type="checkbox"/>		AB <input type="checkbox"/>	Back	<input type="checkbox"/>	<input type="checkbox"/>		
	Nose / Sinuses	<input type="checkbox"/>	<input type="checkbox"/>		V. Veins	<input type="checkbox"/>	<input type="checkbox"/>		Edema	<input type="checkbox"/>	<input type="checkbox"/>	Hips	<input type="checkbox"/>	<input type="checkbox"/>
	Teeth / Gums	<input type="checkbox"/>	<input type="checkbox"/>		Cyanosis	<input type="checkbox"/>	<input type="checkbox"/>		Clubbing	<input type="checkbox"/>	<input type="checkbox"/>	Knees	<input type="checkbox"/>	<input type="checkbox"/>
	Pharynx	<input type="checkbox"/>	<input type="checkbox"/>		♀ - Vulva / Vagina	<input type="checkbox"/>	<input type="checkbox"/>				Ankles / Feet	<input type="checkbox"/>	<input type="checkbox"/>	
	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>		Adnexae	<input type="checkbox"/>	<input type="checkbox"/>				Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	
C H E S T	Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>	G E N I T - U R I N E	Cervix	<input type="checkbox"/>	<input type="checkbox"/>	N E U R O L O G I C A L E X A M	Gait	<input type="checkbox"/>	<input type="checkbox"/>			
	Carotid Bruits	<input type="checkbox"/>	<input type="checkbox"/>		Uterus	<input type="checkbox"/>	<input type="checkbox"/>		Muscle Atrophy	<input type="checkbox"/>	<input type="checkbox"/>			
	Chest-Lungs	<input type="checkbox"/>	<input type="checkbox"/>		Utero / Rectocele	<input type="checkbox"/>	<input type="checkbox"/>		Cranial Nerves	<input type="checkbox"/>	<input type="checkbox"/>			
	Heart-Apex (Location)				Pap Test (done)	YES <input type="checkbox"/>	NO <input type="checkbox"/>		Tendon Reflexes	<input type="checkbox"/>	<input type="checkbox"/>			
	Heart Sound	<input type="checkbox"/>	<input type="checkbox"/>		Genitalia - (male)	<input type="checkbox"/>	<input type="checkbox"/>		Romberg	<input type="checkbox"/>	<input type="checkbox"/>			
A B D O M E N	Murmurs / Thrills	<input type="checkbox"/>	<input type="checkbox"/>	A R E C T O	- Prostate	<input type="checkbox"/>	<input type="checkbox"/>	Babinski	<input type="checkbox"/>	<input type="checkbox"/>				
	Breasts & Nipples	<input type="checkbox"/>	<input type="checkbox"/>		Ano-Rectal	<input type="checkbox"/>	<input type="checkbox"/>	Sensory	<input type="checkbox"/>	<input type="checkbox"/>				
	Axillary Nodes	<input type="checkbox"/>	<input type="checkbox"/>		Sigmoidoscopy			Motor	<input type="checkbox"/>	<input type="checkbox"/>				
	Abdominal Masses	<input type="checkbox"/>	<input type="checkbox"/>		D E R M	Skin Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Vibration	<input type="checkbox"/>	<input type="checkbox"/>			
Abdominal Tend	<input type="checkbox"/>	<input type="checkbox"/>	Nail Beds - Fingers	<input type="checkbox"/>		<input type="checkbox"/>	Position	<input type="checkbox"/>	<input type="checkbox"/>					
Liver /Spleen	<input type="checkbox"/>	<input type="checkbox"/>	- Toes	<input type="checkbox"/>		<input type="checkbox"/>	Tremor	<input type="checkbox"/>	<input type="checkbox"/>					
Abdominal Bruits	<input type="checkbox"/>	<input type="checkbox"/>				Rigidity	<input type="checkbox"/>	<input type="checkbox"/>						

I N V E S T I G.	CBC <input type="checkbox"/>	C. X-RAY <input type="checkbox"/>	MAMMOGRAM <input type="checkbox"/>
		E.C.G. <input type="checkbox"/>	

SYNOPSIS	PLANS