

PATIENT NAME: _____

BIRTH DATE: _____

ID NO.: _____

DATE: _____

PHYSICIAN HISTORY

<input type="checkbox"/> NEW PATIENT		<input type="checkbox"/> ESTABLISHED PATIENT		<input type="checkbox"/> CONSULTATION		<input type="checkbox"/> REPORT SENT	
PRIMARY CARE PHYSICIAN:				WHO SENT PATIENT:			
OTHER PHYSICIAN(S):							
CHIEF COMPLAINT (CC) (REQUIRED FOR ALL VISITS EXCEPT PREVENTIVE):				CURRENT PRESCRIPTION MEDICATIONS: <input type="checkbox"/> NONE			
HISTORY OF PRESENT ILLNESS (HPI):				CURRENT NONPRESCRIPTION, COMPLEMENTARY, AND ALTERNATIVE MEDICATIONS: <input type="checkbox"/> NONE			
CHANGES SINCE LAST VISIT		YES	NO	NOTES			
ILLNESSES		<input type="checkbox"/>	<input type="checkbox"/>				
SURGERY		<input type="checkbox"/>	<input type="checkbox"/>				
NEW MEDICATIONS		<input type="checkbox"/>	<input type="checkbox"/>				
CHANGE IN FAMILY HISTORY		<input type="checkbox"/>	<input type="checkbox"/>				
NEW ALLERGIES		<input type="checkbox"/>	<input type="checkbox"/>				
CHANGE IN GYNECOLOGIC HISTORY		<input type="checkbox"/>	<input type="checkbox"/>				
CHANGE IN OBSTETRIC HISTORY		<input type="checkbox"/>	<input type="checkbox"/>				
ALLERGIES (DESCRIBE REACTION): <input type="checkbox"/> NONE							
LAST CERVICAL CANCER SCREENING: <input type="checkbox"/> CYTOLOGY / / / <input type="checkbox"/> HPV TEST / / /							
LAST MAMMOGRAM: / / /							
LAST COLORECTAL SCREENING: / / /							

GYNECOLOGIC HISTORY (PH)

LMP: _____	AGE AT MENARCHE: _____	LENGTH OF FLOW: _____	INTERVAL BETWEEN PERIODS: _____	RECENT CHANGES: _____
SEXUALLY ACTIVE <input type="checkbox"/> YES <input type="checkbox"/> NO	EVER HAD SEX <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF PARTNERS (LIFETIME): _____		
PARTNERS ARE: <input type="checkbox"/> MEN <input type="checkbox"/> WOMEN <input type="checkbox"/> BOTH				
CURRENT METHOD OF CONTRACEPTION: _____		PAST CONTRACEPTIVE HISTORY: _____		

OBSTETRIC HISTORY (PH)

PREGNANCIES		NUMBER	ABORTIONS		NUMBER	MISCARRIAGES		NUMBER
PREMATURE BIRTHS (<37 WEEKS)			LIVE BIRTHS			LIVING CHILDREN		
NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	PHYSICIAN'S NOTES		
1								
2								
3								
4								
ANY PREGNANCY COMPLICATIONS?								
<input type="checkbox"/> DIABETIS <input type="checkbox"/> HYPERTENSION/HIGH BLOOD PRESSURE <input type="checkbox"/> PREECLAMPSIA/TOXEMIA <input type="checkbox"/> OTHER								
ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? <input type="checkbox"/> NO <input type="checkbox"/> YES HOW TREATED: _____								

PAST HISTORY (PH)

<input type="checkbox"/> NONCONTRIBUTORY <input type="checkbox"/> NO INTERVAL CHANGE SINCE / / /
SURGERIES:
ILLNESSES (PHYSICAL AND MENTAL):
INJURIES:
IMMUNIZATIONS/TUBERCULOSIS TEST:

PHYSICIAN HISTORY (Continued)

PATIENT NAME _____	BIRTH DATE: / /	ID NO.: _____	DATE: / /
--------------------	-----------------	---------------	-----------

FAMILY HISTORY (FH)

<input type="checkbox"/> NONCONTRIBUTORY <input type="checkbox"/> NO INTERVAL CHANGE SINCE: / /			
MOTHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED—CAUSE: _____	AGE: _____	FATHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED—CAUSE: _____	AGE: _____
SIBLINGS: NUMBER LIVING: _____	NUMBER DECEASED: _____	CAUSE(S)/AGE(S): _____	
CHILDREN: NUMBER LIVING: _____	NUMBER DECEASED: _____	CAUSE(S)/AGE(S): _____	
(IF YES, INDICATE WHOM AND AGE AT DIAGNOSIS)			
<input type="checkbox"/> DIABETES	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> HYPERLIPIDEMIA	
<input type="checkbox"/> CANCER	<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> DEEP VEIN THROMBOEMBOLISM/PULMONARY EMBOLISM	
<input type="checkbox"/> OSTEOPOROSIS	<input type="checkbox"/> OTHER ILLNESSES _____		

SOCIAL HISTORY (SH)

<input type="checkbox"/> NONCONTRIBUTORY <input type="checkbox"/> NO INTERVAL CHANGE SINCE: / /			
	YES	NO	NOTES
TOBACCO USE	<input type="checkbox"/>	<input type="checkbox"/>	DIET DISCUSSED <input type="checkbox"/> YES <input type="checkbox"/> NO
ALCOHOL USE—SPECIFY AMOUNT AND TYPE (12 oz beer = 5 oz wine = 1 1/2 oz 40% alc)	<input type="checkbox"/>	<input type="checkbox"/>	FOLIC ACID INTAKE <input type="checkbox"/> YES <input type="checkbox"/> NO
ILLEGAL/STREET DRUG USE	<input type="checkbox"/>	<input type="checkbox"/>	CALCIUM INTAKE <input type="checkbox"/> YES <input type="checkbox"/> NO
MISUSE OF PRESCRIPTION DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	REGULAR EXERCISE <input type="checkbox"/> YES <input type="checkbox"/> NO
INTIMATE PARTNER VIOLENCE	<input type="checkbox"/>	<input type="checkbox"/>	CAFFEINE INTAKE <input type="checkbox"/> YES <input type="checkbox"/> NO
SEXUAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	ADVANCE DIRECTIVE (LIVING WILL) <input type="checkbox"/> YES <input type="checkbox"/> NO
HEALTH HAZARDS AT HOME/WORK	<input type="checkbox"/>	<input type="checkbox"/>	ORGAN DONATION <input type="checkbox"/> YES <input type="checkbox"/> NO
SEAT BELT USE	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____
			<input type="checkbox"/> NO CHANGES SINCE: / /

REVIEW OF SYSTEMS (ROS)

1. CONSTITUTIONAL	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> WEIGHT LOSS	<input type="checkbox"/> WEIGHT GAIN	
	<input type="checkbox"/> FEVER	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> OTHER	TALLEST HEIGHT: _____
2. EYES	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> VISION CHANGE	<input type="checkbox"/> GLASSES/CONTACTS	
	<input type="checkbox"/> OTHER			
3. EAR, NOSE, AND THROAT	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> ULCERS	<input type="checkbox"/> SINUSITIS	
	<input type="checkbox"/> HEADACHE	<input type="checkbox"/> HEARING LOSS	<input type="checkbox"/> OTHER	
4. CARDIOVASCULAR	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> ORTHOPNEA	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> DIFFICULTY BREATHING ON EXERTION
	<input type="checkbox"/> EDEMA	<input type="checkbox"/> PALPITATION	<input type="checkbox"/> OTHER	
5. RESPIRATORY	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> WHEEZING	<input type="checkbox"/> HEMOPTYSIS	
	<input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> COUGH	<input type="checkbox"/> OTHER	
6. GASTROINTESTINAL	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> BLOODY STOOL	<input type="checkbox"/> NAUSEA/VOMITING/INDIGESTION
	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> FLATULENCE	<input type="checkbox"/> PAIN	<input type="checkbox"/> FECAL INCONTINENCE <input type="checkbox"/> OTHER
7. GENITOURINARY	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> HEMATURIA	<input type="checkbox"/> DYSURIA	<input type="checkbox"/> URGENCY
	<input type="checkbox"/> FREQUENCY	<input type="checkbox"/> INCOMPLETE EMPTYING		<input type="checkbox"/> INCONTINENCE
	<input type="checkbox"/> DYSpareunia	<input type="checkbox"/> ABNORMAL OR PAINFUL PERIODS		<input type="checkbox"/> PMS
	<input type="checkbox"/> ABNORMAL VAGINAL BLEEDING	<input type="checkbox"/> ABNORMAL VAGINAL DISCHARGE		<input type="checkbox"/> OTHER
8. MUSCULOSKELETAL	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> MUSCLE WEAKNESS		
	<input type="checkbox"/> MUSCLE OR JOINT PAIN	<input type="checkbox"/> OTHER		
9a. SKIN	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> RASH	<input type="checkbox"/> ULCERS	
	<input type="checkbox"/> DRY SKIN	<input type="checkbox"/> PIGMENTED LESIONS	<input type="checkbox"/> OTHER	
9b. BREAST	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> MASTALGIA		
	<input type="checkbox"/> DISCHARGE	<input type="checkbox"/> MASSES	<input type="checkbox"/> OTHER	
10. NEUROLOGIC	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> SYNCOPE	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> NUMBNESS
	<input type="checkbox"/> TROUBLE WALKING	<input type="checkbox"/> SEVERE MEMORY PROBLEMS	<input type="checkbox"/> OTHER	
11. PSYCHIATRIC	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> CRYING	
	<input type="checkbox"/> SEVERE ANXIETY	<input type="checkbox"/> OTHER		
12. ENDOCRINE	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HYPOTHYROID	<input type="checkbox"/> HYPERTHYROID
	<input type="checkbox"/> HOT FLASHES	<input type="checkbox"/> HAIR LOSS	<input type="checkbox"/> HEAT/COLD INTOLERANCE	<input type="checkbox"/> OTHER
13. HEMATOLOGIC/LYMPHATIC	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> BRUISES		
	<input type="checkbox"/> BLEEDING	<input type="checkbox"/> ADENOPATHY	<input type="checkbox"/> OTHER	
14. ALLERGIC/IMMUNOLOGIC	(SEE FIRST PAGE)			