

Name: _____

Appt Date: _____

Date of Birth: _____

Primary Physician: _____

Referred By: _____

To be completed by patient

Describe in your own words the reason for this visit:

Current Medications: Please list all medications that you are currently taking, including over the counter medications.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.

To be completed by physician.

Chief Complaint:

History of Present Illness:

Name: _____

Appointment Date: _____

To be completed by patient.

Check the following medical conditions that you have currently or have had in the past.

	Current	Past
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Polyps	<input type="checkbox"/>	<input type="checkbox"/>
<i>Emphysema</i>		<input checked="" type="checkbox"/>
<input type="checkbox"/>		
Croup	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Gastroesophageal Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Colitis or Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Please list all hospitalizations (including year and reason)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

To be completed by physician.

Physical Exam:

WT: _____ HT: _____

T: _____ P: _____ BP: _____

General Appearance:

EYES: CONJUNTIVA- NORMAL R L ; RED R L LIDS- NORMAL R L ; EDEMA-

EARS: TMS- NORMAL R L ; DULL R L ; RED R L CANALS- NORMAL OCCLUDED

NOSE: MUCOSA- NORMAL PALE RED EDEMA- R- MILD MODERATE SEVERE L- MILD MODERATE SEVERE MUCOUS- MILD MODERATE COPIOUS SEROUS WHITE MUCOID POLYPS- NONE ; PRESENT R L SEPTUM- MIDLINE ; DEVIATED R L EXCORIATED R L ; PERFORATED

OROPHARYNX: PALATE- NORMAL OTHER: POST PHARYNX- NORMAL INJECTED COBBLESTONED PND

TEETH & GUMS: NORMAL ; OTHER:

FACE/SINUS TENDERNESS:

ABSENT FRONTAL MAX

NECK: NORMAL APPEARANCE

THYROID: NORMAL ENLARGED

LYMPHATICS: NECK AXILLA GROIN

CHEST: VENTILATION- NORMAL RETRACTIONS AUSCULTATION- NORMAL

WHEEZES R L BILAT FVC

RHONCHI R L BILAT

Patient _____

Appt Date _____

For children under 15, complete the following:

1. Birth Weight:
2. Were there any complications following delivery? Yes No
Explain:
3. Has growth and development been normal? Yes No
Explain:
4. Are immunizations up to date?
 Yes No

Social History

Current Occupation: _____

Marital Status: **S** **M** **D** **W**

Hobbies:

Cigarette Smoking History:

Environmental History: (Please check the appropriate boxes.)

Home: House Apartment Condo
 Mobile Home Age: _____

Pets: Cat Indoor Outdoor
 Dog Indoor Outdoor

Smokers: None
 Indoors By: _____
 Outdoors By: _____

Heat: Central Radiator

Air conditioning: Central Window

Pillows: Feather Non-feather Age: _____

Bed: Mattress/Boxspring Waterbed
 Age: _____

Flooring: Hardwood Carpet Age: _____

Basement or Crawlspace:

Dry Damp Musty

To be completed by physician.

Physical Exam (continued):

CVS: *Heart-
 *PV(observ/palp)-

Abdomen: *Tenderness Mass
 *Liver/Spleen- Normal Enlarged

*Extremities:

*Skin: Normal: Other:

Neuro/Psych: *Orientation-

 *Mood/Affect-

Other:

PF:1-5 EPF:6-11 D:12 C:ALL