Patient Name _______________ **AGE** **BP** **PS** **HT** **WT** _____

Reason for visit or Chief Complaint _______________________________________

____

List your PAST SURGICAL HISTORY: **(year/procedure)** ☐ **No Surgical Procedures**

yr _____ **procedure** _______________ **yr** _____ **procedure** _______________

yr _____ **procedure** _______________ **yr** _____ **procedure** _______________

yr _____ **procedure** _______________ **yr** _____ **procedure** _______________

yr _____ **procedure** _______________ **yr** _____ **procedure** _______________

DO YOU HAVE A PERSONAL HISTORY OF:

☐ **Cancer** __________

☐ **Heart Failure (CHF)** _______________ ☐ **Myocardial Infarction (MI)** _______________

☐ **Cardiac Arrythmia** _________________ ☐ **Angioplasties/Stents** ____________________

☐ **Stroke** _____________________

☐ **Diabetes** ______________ ☐**Seizures**_______________ ☐**Asthma** _______________

☐ **Angina** ________________ ☐ **Hypertension** _________________

☐ **COPD/Emphysema** ______________________ ☐ **Sleep Apnea** ____________________

Other Pertinent Medical History, Hospitalization, Etc.: _____________________________

____

____

____

____

Social History: Occupation(s) (if retired, indicate what occupation you were in): _________

____

Do you use:

☐ **Tobacco-if yes, how many packs per day_____per week______**
☐ **Alcohol-if yes, how often,** ☐ **Daily** ☐ **Weekly,** ☐**Monthly,** ☐ **Occasionally**
☐ **Any history of Drug use**
☐ **None of the Above**

FAMILY HISTORY OF (include Family Relation in space provided):
☐**Colon CA** _____________ ☐ **Polyps**____________ ☐ **Colitis**_____________

☐**Liver Disease**_______________ ☐**Ulcer** _______________ ☐ **Gallstones** _____________

☐ **Crohns** _____________ ☐ **Breast CA** ______________ ☐ **Ovarian/Uterine** ___________

☐ **Other Malignancy** _______________________________________

PLEASE FILL OUT BOTH SIDES OF THIS FORM

PERSONAL HISTORY

	DO YOU HAVE ANY OF THESE SYMPTOMS (Please circle)
General	Fatigue / weight gain / weight loss/ fever / chills
Ophthalmologic	Double vision/Blurred vision/Pain/Vision change
ENT	Snoring/Hoarseness/Decreased hearing/Dry mouth/Ear pain/Nosebleed/Sinus pain/Sore throat
Respiratory	Cough/Coughing blood/Shortness of breath/Wheezing
Cardiovascular	Chest pain/Claudication/Fluid accumulation in the legs/Irregular Heartbeat/Palpitations
Gastrointestinal	Food intolerance/Abdominal pain/Blood in stool/Change in bowel habits/Constipation/Decreased appetite/Diarrhea/Difficulty swallowing/Heartburn/Nausea/Rectal bleeding/Vomiting
Hematology	Easy bruising/Swollen glands
Genitourinary	Blood in urine/Frequent urination/Painful urination/Hesitancy/Urgency/Nighttime urination
Women only	Abnormal vaginal bleeding/Vaginal discharge or itching
Musculoskeletal	Change in range of motion/Leg cramps/Muscle aches/Painful joints/Swollen joints
Skin	Pallor/Discoloration/Itching/Nodule(s)/Rash/Skin lesion(s)
Neurologic	Weakness/Dizziness/Fainting/Headache/Seizures/Tingling/Numbness
Psychiatric	Sleep disturbance/Anxiety/Depressed mood

TO BE COMPLETED BY M.D.

HPI	PHYSICAL EXAM	PLAN