Patient's Name _____ DoB _____ Date _____ Chart # _____

History

☐ Previous concerns, consults and procedures reviewed

Interval: ☐ No Change Concerns _____

Current Meds _____

Drug Allergies ☐ Yes ☐ No _____

Past / Social / Family History

Interval: ☐ No Change

Are you: ☐ single ☐ married ☐ divorced ☐ widower ☐ other_____

Do you have children? ☐ Yes ☐ No Ages _____

ROS

Do you have concerns about the following (circle):

	YES	NO
Overall health?	☐	☐
Eating habits / Nutrition, weight loss or gain?	☐	☐
Eye, Ear, Nose, Throat, Sinus problems?	☐	☐
Respiratory problems, frequent infections?	☐	☐
Heart problems, chest pain, shortness of breath, ↑ blood pressure?	☐	☐
Abdominal / GI problems?	☐	☐
Urinary problems?	☐	☐
Joint or muscle problems?	☐	☐
Headaches, dizziness, numbness, weakness?	☐	☐
Allergies: food, hay fever, asthma, eczema?	☐	☐
Problems at work?	☐	☐
Stress, sadness, depression, mood changes?	☐	☐
Sexual problems, sexually transmitted diseases, AIDS / HIV	☐	☐
Are you sexually active now?	☐	☐
With: ☐ opposite sex ☐ same sex ☐ single partner ☐ multiple partners		
Have you had any difficulty getting or sustaining an erection?	☐	☐
Have you seen a dentist in the past year?	☐	☐
Do you use cigarettes, smokeless tobacco?	☐	☐
Do you use recreational drugs?	☐	☐
Do you drink alcohol? If yes, ☐ beer ☐ wine ☐ liquor;	☐	☐
Do you drink: ☐ rarely ☐ weekly ☐ daily # of drinks		
Have you been drunk in the past month?	☐	☐

Do you have any other concerns? ☐ Yes ☐ No _____

Patient Sig. _____

Hx reviewed by _____

Physical Exam

☑ Nl ☒ Abn *Circle & discuss pertinent nl. & abn. findings*

Weight_____ Height_____ B.P._____ / _____

☐ **Gen. App.** Temp_____ Pulse_____ Resp_____

☐ **1. Hd / Face / Neck** appearance, asymmetry, tender, defects, masses_____

☐ **2. Eyes** lids, conjunctiva, sclera, pupils, muscles, fundi, vision_____

☐ **3. ENMT** canals, TMs, hearing, nasal mucosa, gums, teeth, pharnyx_____

☐ **4. Resp** ↑ effort, wheezes, rales, ↓breath sounds, dullness_____

☐ **5. Cardio-V** p.m.i., rate, rhythm, pulses, bruits, murmurs, edema_____

☐ **6. Chest (br/axil)** nipples, shape, symmetry, swelling, masses_____

☐ **7. Hem / Lymph** petechiae, bruises, enl. nodes_____

☐ **8. Abd / GI** liver, spleen, scars, distention, tenderness, masses_____

☐ **9. GU / Genitalia** penis, scrotum, testes, drainage, lesions, masses_____

☐ **10. Integumentary** hair, nails, skin, rashes, defects_____

☐ **11. Back / Mus-Skel** range of motion, swelling, weakness, scoliosis_____

☐ **12. Neuro / Psych** _____

Impression

☐ Normal Exam

Procedures

Immuniz. Current?
☐ Yes ☐ No

*at risk
**no immunity

☐ Td, Tdap	☐ CBC	☐ Colonoscopy
☐ Hep A*	☐ Urine	☐ CXR / EKG
☐ Hep B*	☐ Glucose	☐ PPD*
☐ Influenza*	☐ Cholesterol	☐ Gonorrhea*
☐ MMR**	☐ BMI	☐ Chlamydia*
☐ Pneumo*	☐ Lipid	☐ Syphilis*
☐ Varicella**	☐ Stool Guaiac	☐ HIV*
☐ Meningococcal*	☐ Sigmoidoscopy	

Plan / Treatment

☐ Basic instructions given; patient seemed to understand

Next Visit_____ ☐ Referral

Anticipatory Guidance

☐ Diet / Nutr / Vit	☐ Sun	☐ Auto safety
☐ Exercise	☐ Smoking	☐ Gun safety
☐ Cardio-V risks	☐ Drugs, alcohol	☐ Domestic violence
☐ Aspirin proph	☐ Sexual / STD's	☐ Stress
☐ Prostate cancer screen	☐ Self exam: testes, skin	

Provider Sig. _____ Date _____

40-59 Male

Español al dorso de esta hoja