PRIME HealthCare, PC

Physical Exam History

*Office:*_____

All Patients: Please complete pages 1, 2 & 3 and SIGN page 3

Last Name	First Name	Date of Birth	Today's Date

Circle the number of years of formal education you have completed

<8	8	9	10	11	12	13	14	15	16	>16

Please circle the term best describes your current employment status and describe.

Employed	Describe:
Retired	Previous Job:
Unemployed	Previous Job:
Student	Where?

Please state in one or two sentences any current concerns you have.

Please list all previous operations with approximate dates. Circle* None *if applicable.

1. **None**	6.
2.	7.
3.	8.
4.	9.
5.	10.

Please check the boxes next to all illness you have or have had.

☐ Atrial Fibrillation	☐ Asthma	☐ Crohn's Disease	☐ Esophagitis	☐ Excessive Alcohol Use
☐ Angina Pectoris	☐ Tuberculosis	☐ Ulcerative Colitis	☐ Anemia	☐ Drug Abuse
☐ Artificial Heart Valve	☐ HIV/AIDS	☐ Liver Cirrhosis	☐ Latex Allergy	☐ Depression
☐ High Blood Pressure	☐ Diabetes	☐ Hepatitis	☐ Cancer: Colon	☐ Anxiety
☐ Pacemaker	☐ Osteoporosis	☐ Gallstones	☐ Cancer: Stomach	☐ Suicide Attempt
☐ High Cholesterol	☐ Thyroid Disorder	☐ Lactose Intolerance	☐ Cancer: Pancreas	☐ Stroke
☐ Heart Attack	☐ Colon Polyps	☐ Pancreatitis	☐ Cancer: Prostate	☐ Migraine Headache
☐ Bleeding Disorder	☐ Irritable Bowel	☐ Diverticulosis	☐ Cancer: Esophagus	☐ Endometriosis
☐ Emphysema	☐ Ulcers	☐ Sprue	☐ Cancer: Breast	☐ Arthritis
☐ Eating Disorders	☐ Sexually Transmitted Disease		☐ History of Physical or Emotional Abuse	

List any other illnesses. Circle* None *if applicable.

1. **None**	4.
2.	5.
3.	6.

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Last Name	*First Name*

Please list any family members who have had any of the following problems.

Disease	Relation to you	Disease	Relation to you
Cancer: Colon		Colon Polyps	
Cancer: Breast		Colitis	
Cancer: Prostate		Bleeding Problems	
Cancer: Other:		Liver Disease (cirrhosis)	
Obesity		Alcohol Abuse	
Diabetes		Hepatitis	
Hypertension		Osteoporosis	
Heart Disease		Depression	
High Cholesterol		Hemochromatosis	
Other:		Other:	

List all your medications (including aspirin & laxatives). Circle None if appropriate.

Name of Drug	Dose? (e.g. mg)	How Often?
None		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

List all your medications allergies. Circle None if appropriate.

1. None	*4.*	*7.*
2.	*5.*	*8.*
3.	*6.*	*9.*

Describe your use of the following. Circle None if appropriate.

Tobacco Use	None	# ___ Packs per day for ____ years	Stopped ____ years ago
Alcohol Use	None	Amount:	Stopped ____ years ago
Illegal Drug Use	None	Type & Amount:	Stopped ____ years ago
Coffee/Tea	None	8 oz. cups per day:	
Seat Belt Use	Always	Describe:	
Exercise	None	Describe:	

Please circle your answer.

Have you been vaccinated against Hepatitis B?	Yes	Never	Don't Know
Date of last colonoscopy (if over age 50)	Year	Never	Don't Know
Date of last mammogram (if female)	Year	Never	Don't Know
Date of last tetanus vaccination	Year	Never	Don't Know
Date of last pneumonia vaccination	Year	Never	Don't Know
Date of last bone density test (for osteoporosis)	Year	Never	Don't Know
Date of last flu vaccination	Year	Never	Don't Know
Date of last shingles vaccination	Year	Never	Don't Know
Name of your Gynecologist & last appointment date	Name		Date

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Last Name	*First Name*

Please indicate whether you experience these symptoms. Circle yes or no.

Symptoms			Physician's Comments
Lack of Energy	Yes	No	**Constitutional**
Trouble Sleeping	Yes	No	
Weight Loss (10 lbs in 1 year)	Yes	No	
Weight Gain (10 lbs in 1 year)	Yes	No	
Fevers	Yes	No	
Hard or Infrequent Bowel Movements	Yes	No	**GI**
Loose or Frequent Bowel Movements	Yes	No	
Blood in Bowel Movements	Yes	No	
Vomit Blood	Yes	No	
Indigestion/Heartburn	Yes	No	
Food Sticks When Swallowing	Yes	No	
Painful Swallowing	Yes	No	
Yellow Jaundice	Yes	No	
Chest Pain	Yes	No	**Cardiovascular**
Palpitations/Irregular Heartbeat	Yes	No	
Swollen Legs	Yes	No	
Fainting	Yes	No	
Shortness of Breath	Yes	No	**Respiratory**
Asthma	Yes	No	
Wheezing/Coughing	Yes	No	
Cough	Yes	No	
Coughing up Blood	Yes	No	
Frequent Urination	Yes	No	**GU**
Blood in Urine	Yes	No	
Difficulty Urinating/Incontinence	Yes	No	
Could you be Pregnant?	Yes	No	
Problem with Menses	Yes	No	
Joint Swelling	Yes	No	**Musculoskeletal**
Joint Redness	Yes	No	
Muscle Aches	Yes	No	
Breast Lump	Yes	No	**Breast/Skin**
Skin Problems/Unusual or New Rash	Yes	No	
Localized Weakness	Yes	No	**Neuro**
Visual Changes	Yes	No	
Seizures	Yes	No	
Headaches	Yes	No	
Falls	Yes	No	
Loss of Memory	Yes	No	**Psychological**
Depression/Suicide Attempts	Yes	No	
Do you feel safe in current relationship?	Yes	No	
Hallucinations	Yes	No	
Anxiety	Yes	No	
Hot/Cold Intolerance	Yes	No	**Endocrine**
Excessive Thirst	Yes	No	
Bleeding	Yes	No	**Hemo**
Easy Bruising	Yes	No	
Allergy to Shellfish	Yes	No	**Allergy**
Allergy to X-Ray Dye	Yes	No	

Patient Signature: _____ ***Date:*** _____

Patients should leave this page blank!

Physician Comments: **BP / P Wgt. Hgt. BMI**

System				Other Comments
General Appearance	Nutrition	WNL	Obese Cachetic	
HEENT	Sclera	WNL	Icteric	
	Conjunctiva	WNL	Pale	
	Ears	WNL	Otitis Wax	
Resp	Lungs	WNL	Ronchi Rales Wheeze	
Breast		WNL		
CV	Rate	WNL	Irregular Tachycardia	
	Murmur	No	Yes	
	JVD	No	Yes	
Abdomen	Distention	No	Distended Soft Firm	
	Bowel sounds	WNL	↓ ↑ Absent	
	Tenderness	No	Yes Guarding Rigid	
	Liver Size	WNL	Enlarged: _____cm	
	Spleen tip	No	Yes	
	Stool heme	Neg	Positive melena BRB	
Prostate		WNL		
Extrem	Edema	No	Yes	
Skin	Jaundice	No	Yes	
	Petechia	No	Yes	
Neuro	Alert & Orient	Yes	x2 x1	
	Encephalopathy	No	Yes	
	CN	WNL		U/A:
	DTR	WNL		EKG:

Impression	**Plan**

Mammography Recommended	**Colonoscopy Recommended**	**PSA Recommended**	**Blood Work Ordered**
US CT MRI CXR	Vaccine: Flu Pneum Tetanus	Cholesterol Advice Given	Exercise Advice Given
Hemoccult cards given to patient	Old records: Patient to obtain Office to obtain	Weight Advice Given IBW ____ Oral ____	BP Advice Given
Bone Density Recommended	ETT PFT	Advised to stop smoking	Alcohol/Drug Advice Given
Responsible MD Coumadin _____ Mammo_____ GYN Ex _____	Consults	Follow up	

M.D. Signature:_____ ***Date:***_____

The Patient Health Questionnaire
Nine-symptom Checklist

Name_____ Date_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1) Little interest or pleasure in doing things	0	1	2	3
2) Feeling down, depressed, or hopeless	0	1	2	3
3) Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4) Feeling tired or having little energy	0	1	2	3
5) Poor appetite or overeating	0	1	2	3
6) Feeling bad about yourself – that you are a failure or have let yourself or your family down	0	1	2	3
7) Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8) Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9) Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
(For office coding: Total Score)	____	____	____	____

If you have experienced any of these problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult