HEALTH HISTORY

NEW___ CONSULT___ **Date _____**

1. Reason for your visit today _____
2. **Please indicate if you are having any current problems signs or symptoms in any of the following areas:**

❑ General Wellness ❑ Eyes ❑ Skin ❑ Ears, Nose, Throat ❑ Stomach/Digestion ❑ Lungs/Breathing ❑ Heart/Circulation ❑ Muscles/Joints/Bones	❑ Neurological ❑ Allergies ❑ Reproductive/Urinary ❑ Thyroid/Endocrine ❑ Psychiatric ❑ Blood/Lymph ❑ Other ❑ Other	Physician Comments – Review of Systems ❑ All other systems negative ROS: 1 prob. Pertinent, 2-9 extended, 10+ complete

3. **Previous Surgeries/Dates:**

4. **Allergies to MEDICATIONS**

5. **What is your Social History?**

Marital Status: ☐ Single, ☐ Married, ☐ Divorced, ☐ Widow/Widower, Who lives with you? _____

Current Occupation/Employer _____ What kind of work? _____

Do you smoke/tobacco use? _____ How many packs a day? _____ For how many years? _____

Do you drink alcohol? _____ How many drinks per day? _____ per week? _____ per month? _____

Have you ever cut down on drinking? _____ Have you ever felt guilty about drinking? _____

Have you ever had arguments with your friends or family about your drinking? _____

Have you ever had to drink in the mornings as an eye-opener? _____

Have you ever had a blood transfusion? _____ If so, when? _____ Have you ever had chemotherapy or radiation? _____

Have you ever donated blood? _____ If so, when? _____ Have you ever been in jail? _____

Are you sexually active? _____ Have you ever used illicit drugs? _____ If yes, what kind? _____

7. **What is the Health Status of Your Family?**

Mother: _____ Father: _____

Brothers/Sisters: _____

Family Illnesses: ☐ Heart Disease ☐ Strokes ☐ High Blood Pressure ☐ Diabetes ☐ Cancer , Site_____

Please list your other physicians/specialists:

(Please Print) Patient Name_____ DOB_____

Patient evaluated at the request of: _____

Chief Complaint: _____

History of Present Illness: *(Location, Quality, Timing, Severity, Duration, Context, Modifying Factors, Assoc. signs/symptoms) (1-3 brief, 4+ extended)*

OR Status of Chronic or Inactive Conditions *(3 or more = extended w/o HPI)* ***PTO***

EXAM

1. Constitutional **BP** _____ **Pulse** _____ **Height** _____ **Weight** _____ **O2** _____ **BMI** _____

Appearance: ☐ **Well Developed** ☐ **Ill-Appearing** ☐ **Cachectic**

2. Eyes
- Conjunctivae and lids ☐ Normal _____
- Pupils and irises ☐ Normal _____

3. Ears/Nose/Mouth/Throat
- Teeth, gums, lips ☐ Normal _____
- External inspection of ears and nose ☐ Normal _____

4. Neck
- Neck ☐ Normal _____
- Thyroid ☐ Normal _____

5. Respiratory
- Palpation of chest ☐ Normal _____
- Auscultation/breath sounds ☐ Clear _____

6. Cardiovascular
- Heart sounds, murmurs ☐ Normal _____
- Pedal pulses ☐ Normal _____
- Extremity edema/varicosities ☐ Absent _____

7. Chest (Breast)
- Symmetry ☐ Normal _____
- Masses ☐ Normal _____

8. Gastroentestinal
- Bowels sounds ☐ Normal _____
- Tenderness/Masses ☐ No _____
- Hepatosplenomegaly ☐ No _____
- Hernia ☐ No _____
- Anus, perineum, and rectum ☐ Normal _____
- Other _____ ☐ Normal _____
- Obtain stool sample (if indicated) Normal _____

9. Musculoskeletal
- Gait w/notation of ability ☐ Normal _____
- Exercise program ☐ _____
- Assessment of muscle strength & tone ☐ Normal _____

10. Skin
- Inspect skin & SC tissue ☐ Normal _____
- Palpation ☐ Normal _____

11. Psychiatric
- Oriented: Person, Place, Time ☐ Yes _____
- Mood & affect (depressed, anxious) ☐ No _____

Investigations and labs reviewed:

Labs: CT: U/S:

Previous EGD: Colonoscopy: ERCP: Capsule:

IMPRESSION

PLAN

EGD _____ COLONOSCOPY _____ ERCP _____ CAPSULE _____

Patient encouraged to establish with a PCP. _____

Malampatti Stage 1 2 3 4

PATIENT COUNSELED REGARDING
DIET, EXERCISE AND SIDE EFFECTS
OF MEDICATIONS IN DETAIL. _____

*Check Imaging Study (USG, CT, MRI)

*Check labs including _____
_____
_____

DISCUSSION:

Note: The risk of Endoscopy, including perforation, bleeding and drug reaction were explained to the patient in detail.

Next Appointment: _____

Prophylactic Antibiotic
YES _____ NO _____

All pages of this document have been reviewed. _____, MD

ASA CLASSIFICATION
HIPPA COMPLIANT

Billed by: _____
DATE: _____