HISTORY AND PHYSICAL DATA
INTERNAL MEDICINE DIVISION of Drs. Waldman and Money, PA

Name____________________________ **Date of Birth**________________ **Age**_______ **Date of Exam**_________________

CURRENT HEALTH CONCERNS (Please identify in the space below the purpose for this examination and any problems or current medical conditions that you wish to have evaluated at this time.)

____
____
____

MEDICAL PROBLEMS (Please identify which medical problems you have now or have experienced in the past)

☐ Hypertension	☐ Hives	☐ Heart Disease	☐ Diverticulosis	☐ Cancer__________(type)
☐ Stroke	☐ Allergy symptoms	☐ Heart Failure	☐ Gastric Ulcer	☐ Rheumatoid arthritis
☐ Migraine	☐ Sinusitis	☐ Atrial Fibrillation	☐ Acid Reflux	☐ Osteoarthritis
☐ Stroke	☐ Asthma	☐ Elevated cholesterol	☐ Kidney Stones	☐ Gout
☐ Seizures	☐ Chronic Bronchitis	☐ Heart Valve Disease	☐ Kidney Disease	☐ Blood Clots
☐ Depression	☐ Emphysema	☐ Diabetes	☐ Hepatitis	☐ Fractures
☐ Panic Attacks	☐ Glaucoma	☐ Thyroid Diseases	☐ Prior use of IV Drugs	☐ Prior Blood Transfusions
☐ Chronic Anxiety	☐ Sleep Apnea	☐ Other Conditions ______________________________		

SURGICAL HISTORY (please list all of the surgeries you have ever had either Hospitalized or as an outpatient)

DATE	Surgery	Location (city)	Complication / Other

OTHER HOSPITALIZATIONS (Please list any other hospitalizations including pregnancy, illness or other procedures)

DATE	Hospitalization purpose	Location	Complication / Other

IMMUNIZATION HISTORY		**FOOD or DRUG Allergies or Intolerances**	
DATE	Tetanus / Diptheria Booster	Food item or drug	Allergic reaction
DATE	Pneumococcus Vaccine		
DATE	Hepatitis B series		
DATE	Hepatitis A series		
		Latex allergy: __yes ___no	

SOCIAL / DIET / EXERCISE HABITS

Have you smoked at any time in your life? ___yes ___no. Formerly or currently using ______# of cigarettes daily for _____years. How many times have you tried to stop smoking_______? Completely stopped smoking in _________.
Do you drink any alcohol? ___yes ___no. If yes, do you use alcohol ____daily, ______x/week, or ______x/year.
Do you follow any special diet? If yes, please identify: ____
How often do you get 30-60 minutes of aerobic exercise? _____daily _____x/week _____x/month
Please identify your sexual preference: ________opposite sex ________same sex

DATE________________ Patient Name____

REVIEW OF SYSTEMS (please identify which of the following medical symptoms you have recently experienced)

Constitutional:	Ears, Nose, Throat, Mouth	Eyes	Skin	Endocrine
☐ Unintentional Weight loss	☐ Hearing change	☐ Vision loss	☐ Skin rashes	☐ Increased thirst
☐ Weight gain	☐ Ear pain or ringing	☐ Vision change	☐ Change of moles	☐ Increased urination
☐ Fever	☐ Worsening nasal congestion	☐ Pain with the eyes	☐ New lumps	☐ Change of heat or cold Tolerance
☐ Chills	☐ Sore throat	☐ Double vision	☐ Change in color	☐ Increased sweating
☐ Increased fatigue	☐ Mouth ulcers / dental problem	☐ Increased itching	☐ Increased bruising	☐ Hot flashes
☐ Loss of appetite	☐ Nose bleeds	☐ Last eye exam____________	☐ Other_________	☐ Other______________
☐ Night Sweats	☐ Trouble swallowing	☐ Other______________		
☐ Other______________	☐ Other____________________			

Hematologic/ Lymphatic	Musculoskeletal	Respiratory	Cardiovascular	Gastrointestinal
☐ Increased bruising	☐ Increased joint tenderness	☐ Cough	☐ Chest pain or pressure	☐ Nausea/Vomiting
☐ Increased Bleeding	☐ Joint swelling	☐ Shortness of breath	☐ Heart racing or skipping	☐ Heartburn
☐ Swollen lymph nodes	☐ Increased muscle aching	☐ Wheezing	☐ Trouble breathing with exercise	☐ Diarrhea
☐ Frequent infections	☐ Increased foot/ankle swelling	☐ Chest pain with breathing	☐ Heart murmur	☐ Change in stools
☐ Anemia	☐ Other___________________	☐ Sleeping on more pillows	☐ Other______________	☐ Constipation
☐ Other_________________		☐ Coughing up blood		☐ Abdominal pain
		☐ Other__________________		☐ Blood in stools
				☐ Other___________________

Genitourinary	Neurologic	Psychiatric	New Complaints
☐ Increased urination/ frequency	☐ Increased dizziness	☐ Depression	
☐ Incontinence	☐ Loosing consciousness	☐ Anxiousness	
☐ Increased night time urination	☐ Increased arm/leg weakness	☐ Panic episodes	
☐ Blood in urine	☐ Numbness or arm/leg	☐ Trouble sleeping	
☐ Sexual dysfunction	☐ Memory problems	☐ Loss of concentration	
☐ Change in menses pattern	☐ Increased headaches	☐ Increased mood swings	
☐ Other___________________	☐ Other___________________	☐ Other___________________	

Reviewed During Examination _________ Space for Comments by the reviewer____

____

____

____

CURRENT MEDICATIONS & DOSAGES (please list in the space provided all of your medications including nonprescription agents you are taking)

FAMILY HISTORY (Please identify the appropriate information in the space provided)

MEMBER	Age	Alive	Dead	Current health or cause of death	MEMBER	Age	Alive	Dead	Current health or cause of death
Mother					Father				
Grandmother					Grandmother				
Grandfather					Grandfather				
Sisters 1.					Brothers 1.				
2.					2.				
3.					3.				
4.					4.				
5.					5.				
6.					6.				

Family members who had the following conditions:

Cancer	Diabetes	Stroke
Hypertension	Heart Disease	Sudden Death
Kidney Disease	Thyroid problems	Blood Clots

SOCIAL / OCCUPATIONAL / PERSONAL INFORMATION (Please provide the information requested)

What is your current relationship status: ___single; ___married; ___widowed; ___separated; ___divorced; ___living with a significant other but not married

What is your current occupation____?

If you are retired, what was/were your previous occupation(s):____

Please identify how many other persons are immediately related to you: _____children _____grandchildren ____great grandchildren

Please use the space below to identify your current interest or hobbies: ____

____

TIME PE STARTED _____________ **DATE**___________ Patient Name____

HISTORY OF PRESENT MEDICAL ISSUES (space for additional comments by reviewer) ____
(Location, Time of onset, duration, associated conditions, severity, quality of pain, referral pattern, modifying factors)

____

____

____

____

____

PHYSICAL EXAMINATION (Areas examined and **found normal** are documented by "√ " in space in front of the body area; **abnormal findings** will be noted with "**AB**" with additional comments noted in space for discussion)

Constitution: Height____ Wt____ BP (R) sit______, std______; (L) sit______, std______; Temp_____, Resp_____; Appearance: normal___ other_________

(1) EYES
(R)___ (L)___ Conjunctivae, lids
(R)___ (L)___ Pupils size, reaction to light, Irises,
(R)___ (L)___Sclera
(R)___ (L)___ Fundoscopic exam: disc, exudates, vessels:
___ EOM normal___
Visual Acuity w / wo glasses OD_______ OS_______

(2) EARS, NOSE, MOUTH, THROAT
(R)__ (L)___ External exam ears and nose
(R)__ (L)___ External auditory canal and TM
___Hearing
___Nasal mucosa, septum, turbinates
___Lips, teeth, gums
___Oropharynx, oral mucosa, salivary glands
___Hard and soft palate, tongue, tonsils,
___Posterior pharynx

(3) NECK
___Exam: appearance, masses, lymph nodes
___Thyroid

(4) RESPIRATORY
___Respiratory effort
___Percussion
___Palpation lungs
___Auscultation clear BS

(5) CARDIOVASCULAR
___Palpation PMI Location________________________________
___Auscultation w/o murmur; murmur present: ______________________
Rhythm: ___regular ___occas ectopic ____Irregular, irregular
(R)__ (L)___ Carotid arteries (pulse, bruit)
___Jugular venous distention absent
___Abdominal Aorta (size, bruit)
(R)__ (L)___ Femoral arteries (pulse, bruit)
(R)__ (L)___ Pedal pulses
(R)__ (L)___ Extremities for edema and/or varicosities
(R)__ (L)___ Capillary refill of toes

(6) BREAST
(R)__ (L)___ Inspection for symmetry, discharge, skin changes
(R)__ (L)___ Palpation for masses, tenderness

(7) GASTROINTESTINAL
___Abdomen appearance, masses, tenderness
Bowel Sounds normal___; other________________
___Liver and Spleen
Inguinal Hernia: present___ L / R absent___
Ventral / Umbilical Hernia: present___ Absent__
___Rectal exam: tone normal
Rectal Masses: present___ absent___
Stool guiac: Negative___ Positive___

(8) GENTIOURINARY

MALE
___Scrotal Contents
___Penis
___Prostate exam

FEMALE
___Labia
___Urethra
___Bladder
___Vagina
___Cervix overall appearance
Discharge absent____ ; other_____
___Nulliparous
___Multiparous
___Uterus shape and size
Position anterior____ posterior___
___Adnexa normal without masses

(9) LYMPH NODES
___Neck
___Axillary
___Groin
___Other

(10) MUSCULOSKELETAL
___Gait and Posture
___Digits and Nails
___Joint, bones, muscles
___Head and Neck
___Spine, Ribs, Pelvis
___Right upper extremity
___Left upper extremity
___Right Lower extremity
___Left lower extremity
(Assessment of inspection, ROM, stability, muscle strength and tone)

(11) SKIN & SUBCUTANOUE TISSUES
___Inspection for rashes, moles, ulcers
___Palpation

(12) NEUROLOGIC
___Cranial Nerves
___DTR
Biceps (L) normal___, abn___; (R) normal___abn___
Triceps (L) normal___, abn___; (R) normal___abn___
Knee (L) normal___, abn___; (R) normal___abn___
Ankle (L) normal___, abn___; (R) normal___abn___
___Sensation

(13) PSYCHIATRIC
___Judgment and insight
___Mental Status
___Orientation to time, place, and person
___Recent and remote memory
___Mood and affect

Space for additional Comments:

Space for additional comments on physical examination

Patient Name____

Electrocardiogram performed today and interpretation:____

Notations from Past Medical Records reviewed:____

____

Assessment of Current Medical Problems / Differential Diagnosis where indicated	PLAN
1.____	____
2.____	____
3.____	____
4.____	____
5.____	____
6.____	____
7.____	____
8.____	____
9.____	____
10.____	____
11.____	____
12.____	____

LABORATORY REQUESTED____

RADIOLOGICAL STUDIES REQUESTED____

Preventive or Educational Information Provided:

___Self Breast Examination	___Self Testicular Examination	___Nutritional Guidance	___Exercise Guidance
___Smoking Cessation	___Seat Belt Usage	___Safe Sex Counseling	___Sun Screen Usage
___Diabetic Blood Sugar Monitoring	___Helmet Usage	___Calcium Supplementation for osteoporosis	

FOLLOW-UP OFFICE VISIT IN ______________________________

_____PAST MEDICAL RECORDS REQUESTED

Time Examination Completed_______________

Time Spent Face to Face with Patient_________

SIGNATURE OF EXAMINER____