GHENT FAMILY PRACTICE, INC.

HISTORY FOR COMPLETE PHYSICAL EXAM

PATIENT TO FILL OUT AND BRING IN AT TIME OF APPOINTMENT

Name______________________________ **Marital Status: S M W D** **Date form filled out**________
Occupation:________________________ ☐**retired** **Education:**____
IMMUNIZATIONS: Date of last tetanus:________ Pneumovax:_________Hepatitis B:________Other:______________
PAST MEDICAL HISTORY: (please list all significant medical diagnoses and surgeries)________________________________
____
MEDICATIONS: (name/dose/frequency) [include over the counter meds also] ________________________________
____
ALLERGIES: (please note type of reaction)____
FAMILY HISTORY: ☐Diabetes ☐Hypertension ☐Stroke ☐Heart disease ☐Osteoporosis ☐Cancer _____________
☐Alcohol or drug abuse ☐Bleeding disorder Date of last **Bone Mineral Density** test__________

RISK FACTORS:				
	Smoking:	☐Never smoked	☐I smoke ___ cigarettes/day	☐Quit-year___
	Alcohol:	☐Don't drink	☐Drink 1 oz/day or less	☐Drink more than 1oz/day
	Illicit drugs:	☐Never used	☐Used in past, but not last 3 yrs	☐Have used in last 3 yrs
	Exercise:	☐Never exercise	☐Exercise <3days/week	☐Exercise 3 + times wkl

Your insurance company may deny payment for services they do not consider "reasonable and necessary". If your insurance denies payment for this physical you are to be personally and fully responsible for payment. You may also be responsible for your co-pay and co-insurance payment. Your signature signifies your agreement with this statement:____
Patient Signature

REVIEW OF SYMPTOMS:

1. Eyes/Ears/Nose/Throat
☐Decreased hearing
☐Vertigo (dizziness)
☐Blurred/double vision
☐Chr nasal or sinus congestion
☐Frequent sneezing/itching spells
☐Recurrent nose bleeds
☐Difficulty chewing
☐Painful/swollen gums/painful teeth
☐Chronic hoarseness

2. RESPIRATORY
☐Hx of pneumonia or TB
☐Chronic cough/wheeze (asthma)
☐Bring up >1tbsp phlegm/day
☐Discolored/bloody sputum
☐Shortness of breath

3. CARDIOVASCULAR
☐Angina (pressure in chest)/Pain
☐Palpitations
☐Easy fatiguability
☐Lightheadedness
☐Loss of consciousness
☐Heart murmur/hx Rheumatic fever
☐Varicose veins
☐Blood clots-legs
☐Chronic swelling of feet/ankles
☐Leg pain or cramping

4. GASTROINTESTINAL
☐Difficulty swallowing
☐Heartburn/indigestion/nausea
☐Abdominal pain
☐Chronic constipation
☐Diarrhea
☐Blood or mucus in stool
☐Anal itching or burning

5. MUSCULOSKELETAL
☐Reddened/inflamed joints
☐Shoulder pain ☐Hip/knee pain
☐Difficulty using hands
☐Painful feet/ankles
☐Neck or back pain
☐Deformed joints

6. NEUROLOGIC
☐Numbness/tingling
☐Weakness
☐Headaches
☐Tremors (shakes)
☐Difficulty with memory
☐Difficulty with speech
☐Imbalance

7. REPRODUCTIVE
☐Irregular Menses ☐Heavy menses
☐Abnormal spotting/bleeding
☐Contraception__________________
☐Post-menopause ☐Taking estrogen
☐Vaginal/penile itching or discharge
☐Lesions of vulva or penis

8. UROLOGIC
☐Burning or pain on urination
☐Incontinence of urine
☐Nocturia (voiding at night)
☐Decreased force/caliber of stream
☐Sexually active? Y__ N__
☐Not orgasmic w/ intercourse
☐Pain with intercourse
☐Difficulty getting/maintaining erections

9. DERMATOLOGIC
☐Rash or chronic itching
☐Suspicious moles or other lesions
☐Abnormal hair loss

10. PSYCHOLOGICAL
☐Anxiety/depression
☐Sleeping problems
☐Loss of interest in activities/sex
☐Panic spells
☐Thoughts of suicide

11. CONSTITUTIONAL
☐Change in appetite
☐Weight change (>5lbs.)
☐Fever/sweats/chills
☐Tiredness
☐Easy bruisability/bleeding
☐Swollen glands

12. HEM/LYMPH
☐Anemia
☐Swollen glands
☐Bruise or bleed easily

13. ALLERGY/IMMUNE
☐Seasonal allergies

PHYSICAL EXAM

Name:________________________________

Age:____________ **Date:**__________

CONSTITUTIONAL: WT____lbs HT____in

BP____/____ ____/____ Temp______

Resp_______ Pulse______

☐=neg/norm ❍= defect

APP: ☐ ❍ Nourishment/development/well groomed

EYES: ☐ ❍ PERRLA
☐ ❍ Conjunctiva
☐ ❍ Fundi

EARS: ☐ ❍ Ext canal ☐ ❍ Nasal mucosa/septum/turb
☐ ❍ TM
☐ ❍ Nose-no lesions
☐ ❍ Hearing grossly nl

MOUTH: ☐ ❍ Lips/teeth/gums
☐ ❍ Oral mucosa/palate/tongue/tonsils
☐ ❍ Pharyngeal wall/pyriform sinus
☐ ❍ Speech

NECK: ☐ ❍ Masses ☐ ❍ Trachea position
☐ ❍ Thyroid ☐ ❍ Crepitus
☐ ❍ Appearance ☐ ❍ Symmetry

LYMPH: ☐ ❍ Palpation of neck/axillae/groin/cervical/post occip

CARD: ☐ ❍ Palpitation/PMI/no thrill or heave
☐ ❍ RR, no M, nl S1, S2, neg S3, S4
☐ ❍ Carotids ☐ ❍ no bruits
☐ ❍ Abdominal aorta ☐ ❍ no bruits
☐ ❍ 2+ bilat femoral arteries ☐ ❍ no bruits
☐ ❍ 2+ bilat pedal pulses
☐ ❍ Feet- warm/nl color
☐ ❍ Edema/varicosity in arms/legs

RESP: ☐ ❍ Lungs clear to auscultation
☐ ❍ No respiratory distress
☐ ❍ No fremitus or dullness to percussion

CHEST: ☐ ❍ Inspection/palpation/masses
☐ ❍ Breast-neg discharge/dimpling/tenderness/masses

GU: ☐ ❍ Penis ☐ ❍ Urethral meatus
Male ☐ ❍ Palp prostate, size______, no nodules
☐ ❍ Testicles neg masses/tenderness/swelling
☐ ❍ Epididymus
Female ☐ ❍ External genitalia/urethra/vagina
☐ ❍ Cervix/Uterus/adnexa
☐ ❍ Cysto/rectocele

ABD: ☐ ❍ No H/S megally, masses, tenderness
☐ ❍ Hernia
☐ ❍ Nl anus/rectum/sphincter tone, no masses, rhoids
☐ ❍ Stool occult blood

SKIN: ☐ ❍ Erythema/suspicious lesions/induration
☐ ❍ Ulcers/subcu nodules/tightening
☐ ❍ Toe nails
☐ ❍ Finger nails
☐ ❍ Clubbing/cyanosis/inflammation
☐ ❍ Petechiae/ischemia/infections

	L	R	
MS:	☐ ❍	☐ ❍	Elbows/shoulder: inspect/ROM/tender/lax
	☐ ❍	☐ ❍	Hands/wrists: inspect/ROM/tender
	☐ ❍	☐ ❍	Knee/hip: inspect/ROM/tender/lax
	☐ ❍	☐ ❍	Feet/ankles: inspect/ROM/tender/lax

☐ ❍ Neck/Spine nl/no pain/ROM

NEURO: ☐ ❍ CN II-XII
☐ ❍ Sensation touch/pin
☐ ❍ Vibe/proprioception

L	R	
☐ ❍	☐ ❍	UE: Strength
☐ ❍	☐ ❍	LE: Strength
☐ ❍	☐ ❍	Upper DTR's: Biceps /br. Rad
☐ ❍	☐ ❍	Lower DTR's: Patella /Ankle

☐ ❍ Babinski
☐ ❍ Romberg/F to N/H to S
☐ ❍ Attention span/lang/knowl
☐ ❍ Coordination/gait

PSYCH: ☐ ❍ Judgement/insight
☐ ❍ Alert/oriented X 3
☐ ❍ Recent/remote memory
☐ ❍ Speech
☐ ❍ Mood/affect/thought processes
☐ ❍ Hallucinations/delusions/loose assoc

COMMENTS:________________________________

ASSESSMENT: **PLANS:**

☐Consult______________________________

☐Insurance Authorization Y ___ N ___

Education:

☐See Health Maintenance sheet
☐Risks/side effects of meds
☐Discussed diet
☐Exercise
☐Osteoporosis /BMD
☐Smoking cessation/options
☐Other_______________________________

☐Return to office: ________________

Tests:

☐Hgb	☐Lipid Rx Profile	☐Hemmocults
☐TSH	☐Lipid Profile	☐Flex Sig
☐RPR	☐CBC w/ diff	☐Pap
☐T4/FTI	☐PSA	☐Mammogram
☐HgbA1c	☐U/A	☐dT
☐Chem 7	☐PFT's	☐Pneumovax
☐Chem 12	☐Audiogram	☐Flu Vaccine
☐Folate/B12	☐EKG	☐BMD

☐X-ray__________ ☐Other:__________