

HISTORY AND PHYSICAL EXAMINATION FORM

(This confidential information will be part of your medical record and will not be released without your authorization.)

Please attach more paper if needed

Last Name		First Name		DOB	AGE
Present Occupation			Past Occupation		
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Re-Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partnered					
List household members (Name/Age)					
Name of person to contact in case of emergency		Phone #	Date of Last Physical	Today's Date	

COMPLETE THIS SECTION ONLY IF THIS IS YOUR FIRST PHYSICAL EXAM AT HARTFORD MEDICAL GROUP

Medical Conditions – Check all that apply now or in the past

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcohol or Drug problem | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Lyme disease |
| <input type="checkbox"/> Allergies / Hay fever | <input type="checkbox"/> Gallbladder problem | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches / Numbness | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Arthritis / Gout | <input type="checkbox"/> Heart Trouble/Angina/Heart murmur | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Blood clots/Phlebitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sleep Apnea/ Sleep Problems |
| <input type="checkbox"/> Cancer/Tumor _____ | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Skin Cancer/ Rashes |
| <input type="checkbox"/> Colon/Bowel problem | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach or Duodenal ulcer/Heartburn |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Kidney Problems / Kidney stones | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lung Problems/Asthma | <input type="checkbox"/> Urinary/ Prostate/ Sexual Problems |

LIST ALL HOSPITALIZATIONS, OPERATIONS, SERIOUS INJURIES, AND ILLNESSES SINCE YOUR LAST PHYSICAL EXAM AT HMG

	YEAR	YEAR

CURRENT MEDICINES: List all medications- include hormones, birth control pills, eye drops, vitamins, inhalers, creams, nasal sprays, supplements, and over the counter medicines Check here if none

NAME OF MEDICATION	MILLIGRAMS	TIMES PER DAY	NAME OF MEDICATION	MILLIGRAMS	TIMES PER DAY

ALLERGIES OR REACTIONS: (Medications, foods, insects) Check here if none

Allergy	Describe Reaction	Allergy	Describe Reaction

Screening

Last Name **First** **DOB**

Please list approximate date of your:

Last eye exam? _____ Last dental exam? _____ Last cholesterol check _____ Last diabetes test? _____

If over 50: Stool test for blood _____ Sigmoidoscopy /Colonoscopy: _____

Women:

Date of your last pap smear? _____ Date of your last mammogram? _____ Date of your last bone density? _____

Number of pregnancies _____ Number of live births _____ Number of miscarriages _____ Number of abortions _____

Men – over 50

Date of last prostate exam? _____ Date of last PSA (prostate blood test)? _____

Immunizations

- Date of last tetanus shot? _____ Has it been more than 10 years? YES No
- If you're over 65, have you had the pneumonia shot (pneumovax)? Yes NO
- Do you get an annual "Flu" (Influenza) vaccine? Yes NO
- Have you been exposed to Tuberculosis or had a positive TB test in the past? YES No
- Have you ever had chicken pox or shingles? Yes NO **If yes, when?** _____
- Have you had the Hepatitis B vaccine? Yes NO **If yes, when?** _____
- If female and under 27, have you had the HPV vaccine? Yes NO **If yes, when?** _____
- Do you anticipate foreign travel in the next year? YES No

Lifestyle review

- About how much alcohol do you have on an average day (beer, wine, liquor)? _____ or week? _____
- How many cups of caffeine do you have on an average day (coffee, tea, colas)? _____
- Do you use tobacco products now or did you smoke in the past? YES No **If yes, what type?** _____
- How many/day _____? How many years _____? Age stopped? _____
- Do you sometimes use street drugs (cocaine, marijuana, heroin etc)? YES No
- Do you exercise regularly? Yes NO
- What kind of exercise do you do? _____ How many times a week? _____ For how long? _____
- How many sexual partners have you had over the last 5 years? _____ Men Women Both
- Are you concerned that you may be at risk for HIV or STD? YES No
- Are you on any special kind of diet? YES No **If yes, what kind?** _____
- Do you feel you eat a healthy diet? Yes NO
- Do you eat calcium rich foods like milk, yogurt, cheese, sardines on a regular basis? Yes NO
- Are you happy with your weight? Yes NO
- Have you ever used laxatives or vomited to control your weight? YES No
- Do you always wear seat belts when driving or riding in the car? Yes NO
- Do you wear helmets when appropriate? Yes NO
- Do you have working smoke and carbon monoxide detectors in your home? Yes NO
- Do you have any unsecured firearms in your house? YES No
- Would you consider yourself a happy person? Yes NO
- Have anyone ever sexually, physically or emotionally abused you? YES No
- Are you having any problems with your mood, worries or fears that interfere with your daily activities? YES No
- Are there any health/lifestyle issues you would like to discuss? YES No

If yes, please list them on the next page → → → → → → → → → → → → → → → →

If your mother (m), father (f), sister (s), brother (b) or children (c) have had or currently have
Please list which relative has had the medical problem

I don't know my family medical history

I am adopted

<input type="checkbox"/> I don't know my family medical history		<input type="checkbox"/> I am adopted	
Family member		Family member	Family member
<input type="checkbox"/> Alcohol/drug problem		<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Prostate cancer
<input type="checkbox"/> Breast Cancer		<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Colon cancer/polyps		<input type="checkbox"/> Mental illness/depression	<input type="checkbox"/> Skin cancer
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Suicide	<input type="checkbox"/> Thyroid problem
<input type="checkbox"/> Heart problems		<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other Cancer
<input type="checkbox"/> Other		<input type="checkbox"/> Other	<input type="checkbox"/> Other

Additional Family History _____

Are there any new illnesses in family members? _____

Review of Systems

In general, would you say your health is: Excellent Very Good Good Fair Poor

Are you having or recently had:

- | | | | | | |
|--|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| Fainting or dizzy spells? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Frequent joint/muscle pains? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Weight gain or loss (more than 10 lbs) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Frequent neck or back pain? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequent headaches? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Problems with urination (frequency or control)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Problems with your eyes or vision? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Problems with sex or intercourse? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hearing loss or ear problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Women | | |
| Any changes of your skin? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you check your breast for lumps? | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |
| Moles that are changing any way? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Problems with your breasts or nipples? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of breath? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Problems with your periods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| A cough lasting more than 6 weeks? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Problems with vaginal discharge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Snoring, sleep problems or sleep apnea? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever had an abnormal Pap smear? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest pain or discomfort? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you had an abnormal mammogram? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest pressure with exertion? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Men | | |
| Your heart racing or skipping beats? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever had an undescended testicle? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heartburn, stomach pain or indigestion? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you examine your testicles for lumps? | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |
| Blood or changes in bowel movements? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Are any of your prior illnesses bothering you more recently? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are there any new stresses in your life? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you taken any measures to improve your health recently? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

List any specialists you see on a regular basis: _____

Please give details of above or write down anything else you'd like to discuss at your physical: _____

PHYSICAL EXAMINATION

AN AFFILIATE OF HARTFORD HOSPITAL

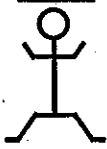
Name of Patient _____ D.O.B. ____ / ____ / ____ Date ____ / ____ / ____

TO BE FILLED OUT BY MEDICAL PERSONNEL

Ht _____ Wt _____ BMI _____ Pulse _____ Resp _____ BP _____

LMP ____ / ____ / ____

Vision: (uncorrected) R: 20/ _____ L: 20/ _____ Both: 20/ _____
(corrected) R: 20/ _____ L: 20/ _____ Both: 20/ _____

	Comments/Abnormal Findings																						
<p>1. General _____ <input type="checkbox"/> WNL</p> <p>a. appearance c. mental development</p> <p>b. gait d. hygiene</p>	<p>Other Special Findings</p>	<p>11. Abdomen _____ <input type="checkbox"/> WNL</p> <p>a. appearance</p> <p>b. organomegaly</p> <p>c. bowel sounds</p> <p>d. hernia</p>																					
<p>2. Skin _____ <input type="checkbox"/> WNL</p> <p>a. rashes d. nails</p> <p>b. sores e. color/texture</p> <p>c. nevi f. scars</p>		<p>12. Genitalia _____ <input type="checkbox"/> WNL</p> <p>Male</p> <p>a. penis discharge</p> <p>b. testes</p> <p>c. hernia</p>																					
<p>3. Head _____ <input type="checkbox"/> WNL</p> <p>a. scalp c. hair pattern</p> <p>b. sinuses</p>		<p>13. Gyn _____ <input type="checkbox"/> WNL</p> <p>Female</p> <p>a. vulva</p> <p>b. urethra</p> <p>c. vagina</p> <p>d. cervix</p> <p>e. adnexa</p> <p>f. uterus</p>																					
<p>4. Eyes _____ <input type="checkbox"/> WNL</p> <p>a. pupils R L</p> <p>b. extraocular movement R L</p> <p>c. conjunctiva R L</p> <p>d. fundi R L</p> <p>e. peripheral vision R L</p>		<p>14. Rectal _____ <input type="checkbox"/> WNL</p> <p>a. masses</p> <p>b. hemorrhoids</p> <p>c. sphincter tone</p> <p>d. prostate</p> <p>e. guaiac <input type="checkbox"/></p>																					
<p>5. Ears _____ <input type="checkbox"/> WNL</p> <p>a. canals R L</p> <p>b. tympanic membrane R L</p> <p>c. hearing R L</p>		<p>15. Musculoskeletal _____ <input type="checkbox"/> WNL</p> <table style="width:100%; border: none;"> <tr> <td></td> <td style="text-align: center;">UE</td> <td style="text-align: center;">LE</td> </tr> <tr> <td>a. range of motion</td> <td style="text-align: center;">R L</td> <td style="text-align: center;">R L</td> </tr> <tr> <td>b. strength/tone</td> <td style="text-align: center;">R L</td> <td style="text-align: center;">R L</td> </tr> <tr> <td>c. edema</td> <td style="text-align: center;">R L</td> <td style="text-align: center;">R L</td> </tr> <tr> <td>d. cyanosis/clubbing</td> <td style="text-align: center;">R L</td> <td style="text-align: center;">R L</td> </tr> <tr> <td>e. spine</td> <td style="text-align: center;">R L</td> <td style="text-align: center;">R L</td> </tr> <tr> <td>f. deformities</td> <td style="text-align: center;">R L</td> <td style="text-align: center;">R L</td> </tr> </table>		UE	LE	a. range of motion	R L	R L	b. strength/tone	R L	R L	c. edema	R L	R L	d. cyanosis/clubbing	R L	R L	e. spine	R L	R L	f. deformities	R L	R L
		UE	LE																				
a. range of motion		R L	R L																				
b. strength/tone		R L	R L																				
c. edema		R L	R L																				
d. cyanosis/clubbing		R L	R L																				
e. spine		R L	R L																				
f. deformities		R L	R L																				
<p>6. Nose/Throat _____ <input type="checkbox"/> WNL</p> <p>a. mucosa c. pharynx</p> <p>b. septum d. dentition</p>		<p>16. Neurological _____ <input type="checkbox"/> WNL</p> <div style="text-align: center;">  </div> <p>a. reflexes</p> <p>b. cranial nerves</p> <p>c. motor/sensory</p> <p>d. mental status</p> <p>e. Romberg</p>																					
<p>7. Neck _____ <input type="checkbox"/> WNL</p> <p>a. range of motion d. bruits</p> <p>b. supple e. adenopathy</p> <p>c. thyroid</p>		<p>17. Peripheral Vascular _____ <input type="checkbox"/> WNL</p> <p>a. pulses</p>																					
<p>8. Chest/Lungs _____ <input type="checkbox"/> WNL</p> <p>a. symmetry</p> <p>b. adventitious sounds</p> <p>c. air entry</p> <p>d. percussion</p>		<p>18. Lymphadenopathy _____ <input type="checkbox"/> WNL</p>																					
<p>9. Heart _____ <input type="checkbox"/> WNL</p> <p>a. rate d. ectopic beats</p> <p>b. rhythm e. PMI</p> <p>c. murmurs</p>																							
<p>10. Breasts _____ <input type="checkbox"/> WNL</p> <p>a. lesions/masses R L</p> <p>b. nipple discharge R L</p>																							

<p>Patient Education: <input type="checkbox"/> tobacco</p> <p>Check box if topic Discussed. <input type="checkbox"/> alcohol / drugs</p> <p><input type="checkbox"/> STDs / HIV / hepatitis</p> <p><input type="checkbox"/> Family Planning</p>	<p><input type="checkbox"/> diet / exercise</p> <p><input type="checkbox"/> seatbelt/helmet use/dom. Violence</p> <p><input type="checkbox"/> cancer screening</p> <p><input type="checkbox"/> sun exposure/skin self exam</p>	<p><input type="checkbox"/> BSE / mammo</p> <p><input type="checkbox"/> PAP</p> <p><input type="checkbox"/> bone density test</p> <p><input type="checkbox"/> menopause/estrogen</p>	<p><input type="checkbox"/> calcium/vit/herbals</p> <p><input type="checkbox"/> immune/TB screening</p> <p><input type="checkbox"/> Living will/DNR</p> <p><input type="checkbox"/> Other _____</p>
---	--	--	---

Print Name _____ Signed _____