Name: _____ Date of visit: _____

THIS SECTION TO BE COMPLETED BY PATIENT

General Information:

Are you…. □ single □ married □ divorced □ widowed □ partnered

Do you have children…. □ yes □ no ages _____

Occupation: _____

● **Review of Systems (circle any present concerns)**

Are you experiencing any of these symptoms?

1. eating habits, weight loss, ↓ energy, sleep habits	□Yes	□No
2. eye pain, redness, tearing, drainage, blurred or ↓ vision	□Yes	□No
3. ears: pain, ↓ hearing, nose, mouth, throat, sinus problems	□Yes	□No
4, heart problems: chest pain, ↑ blood pressure, leg swelling	□Yes	□No
5. lung problems: difficulty breathing, wheezing, infections	□Yes	□No
6. abdominal pain: vomiting, diarrhea, constipation, blood	□Yes	□No
7. kidney or bladder problems: infection, blood in urine	□Yes	□No
8. joint pain, stiffness, swelling, muscle pain, weakness	□Yes	□No
9. skin: rashes, itching, dryness, hair or nail problems	□Yes	□No
10. recurrent headaches, dizziness, numbness, weakness	□Yes	□No
11. stress, anxiety, sadness, depression, suicidal thoughts	□Yes	□No
12. excessive thirst or hunger, ↑ urination, weight loss	□Yes	□No
13. paleness, anemia, easy bruising, swollen glands	□Yes	□No
14. allergies: food, hay fever, asthma, ↑ infections	□Yes	□No
15. changes in size or shape of breasts, lumps, tenderness nipple discharge or bleeding.	□Yes	□No
16. vaginal bleeding, dryness, itch, discharge, lumps, pain	□Yes	□No
17. sexual concerns, sexual orientation, etc	□Yes	□No

● Personal/Social History

Approximate date of last pap test? _____

Have you had a mammogram? Date_____

Are you sexually active now? □Yes □No

□ same sex □ opposite sex

□ single partner □ multiple partners

Do you have sexual concerns? □Yes □No

Have you ever needed help with (circle) shopping, chores, climbing stairs, going to the bathroom, bathing, dressing taking medication □Yes □No

Do you feel safe/comfortable in your home with your family and/or your partner relationship? □Yes □No

Do you smoke or use tobacco products now? □Yes □No

Do you use recreational drugs? □Yes □No

Do you drink alcohol? □Yes □No

If yes, □ daily □ weekly □ rarely _____ of drinks

Do you engage in physical activity? □Yes □No

If yes, □ daily □ 2x-3x/wk □ 4x-5x/wk □ erratically

Do you have any concerns you wish to discuss? □Yes □ No

Patient's Signature _____

THIS SECTION TO BE COMPLETED BY PHYSICIAN

● **Chief Concern/HPI**

Update Past Medical Family History

Blue sheet reviewed/updated for PMHx / PSHx / FHx

□ Medications, supplements, herbals, allergies per med sheet

General Health Practices

Provider's Signature _____

60+ Female

Name:_____

Date of Birth _____

Physical Exam √ = normal X = Abnormal

Circle and describe all abnormal and pertinent normal findings

1. ☐ Constitutional

T _____ RR_____

BP _____ P_____

HT_____ WT_____

BMI_____

General Appearance_____

2. ☐ Eyes: lids, conjunctive, sclera, pupils, irises

3. ☐ Mouth: dentition, gums

4. ☐ Neck: thyroid, lymph nodes

5. ☐ Cardiovascular: p.m.i., rate, rhythm, murmurs

6. ☐ Respiratory: ↑ effort, wheezes, rales, ↓ breath sounds

7. ☐ Abdomen: scars, tenderness, bowel sounds, bruits, masses, liver, spleen

8. ☐ Skin: concerning growths

9. ☐ Musculoskeletal: adequate muscle strength, balance, gait

10. ☐ Other: List other systems examined and findings

Assessment/Plan

*Provider's signature*_____