NEW PATIENT CONSULTATION

NAME/DOB:_____ **DATE:**_____

PAST SURGICAL HISTORY:

___GALLBLADDER ___STOMACH
___APPENDIX ___HEMORRHOIDS
___UTERUS ___ESOPHAGUS
___OVARIES ___HEART:
___COLON ___BYPASS
___LUNGS ___STENTS
___HERNIA ___VALVES
___KNEE ___DEFIBRILLATOR
___ HIP ___PACEMAKER

SOCIAL HISTORY:

___SMOKER: HOW MUCH PER DAY_____
___ALCOHOL: HOW MUCH PER DAY_____
___COFFEE: HOW MUCH PER DAY _____
___SODAS: HOW MUCH PER DAY _____
OCCUPATION: _____
IMMUNIZATIONS:
___FLU ___HAV
___PNEUMOCOCCAL ___HBV

PAST MEDICAL HISTORY:

___HIGH BLOOD PRESSURE
___DIABETES
___HIGH CHOLESTEROL
___ARTHRITIS: ___DJD ___RA
___EMPHYSEMA OR ASTHMA
___CONGESTIVE HEART FAILURE
___ARRHYTHMIAS: ___A.FIB ___V.FIB
___CORONARY DISEASE
___STROKES
___SLEEP APNEA
___THYROID
___SEIZURES
___KIDNEY DISEASE
___PARKINSON'S
___MIGRAINE HEADACHE
___CANCER_____
___FIBROMYALGIA
___OTHER: _____

PAST G.I. HISTORY:

___ACID REFLUX DISEASE
___PUD (ULCERS)
___IBS (IRRITABLE BOWEL)
___CROHN'S
___COLON CANCER
___DIVERTICULITIS
___ULCERATIVE COLITIS
___PROCTITIS
___CIRRHOSIS
___HEPATITIS ___C ___ B
___COLON POLYPS
___PANCREATITIS

FAMILY HISTORY:

____COLON POLYPS
____COLON CANCER
____LIVER DISEASE
____PANCREATIC CANCER
____UTERINE OR OVARIAN CANCER
____CROHN'S DISEASE
____ESOPHAGEAL CANCER

HAVE YOU EVER HAD A COLONOSCOPY? _____ WHEN? _____ WHERE? _____

REVIEW OF SYSTEMS: PLEASE √ BELOW IF EXPERIENCED OVER LAST 2 WEEKS

III: 1 IV: 2-9 V: 10

NEUROLGIC:
___FREQUENT HEADACHE
___TREMOR

MUSCULO-SKELETAL:
___ARTHRITIS
___SORE MUSCLES

PSYCHIATRIC:
___ANXIETY
___DEPRESSION

HEMTOLOGIC:
___EASY BRUISING
___ANEMIA

CARDIOVASCULAR:
___CHEST PAIN
___FAINTING

GENERAL:
___LOSS OF APPETITE
___WEIGHT LOSS
___FEVER

RESPIRATORY:
___HOARSNESS OR COUGH
___SHORT OF BREATH

ENDOCRINE:
___THIRSTY
___2 HOT/2 COLD

DRUG ALLERGIES:
1._____
2._____
3._____
4._____
5._____

MEDICATION:
1._____DOSAGE_____
2._____DOSAGE_____
3._____DOSAGE_____
4._____DOSAGE_____
5._____DOSAGE _____
6._____DOSAGE_____
7._____DOSAGE_____
8._____DOSAGE_____
9._____DOSAGE_____
10._____DOSAGE_____

PHARMACY_____ PHONE NUMBER _____

FOR DOCTOR USE ONLY

PHYSICAL EXAM: WT._____ HT_____ BP_____ HR_____

III: 6B IV: 2B/6 V: 2B/9

GENERAL:
GROOMING:_____NORMAL ____ABNORMAL
NUTRITION: ____NORMAL ____ABNORMAL

CARDIOVASCULAR:
____RRR _____IRR
____NO MURMUR ____+MURMUR_____
CAROTIDS ____NORMAL ____ABNORMAL

SKIN:
INSPECTION: _____NORMAL _____ABNORMAL
TURGOR: _____NORMAL _____ABNORMAL

NECK:
_____SUPPLE _____ABNORMAL
THYROID:_____NORMAL _____ABNORMAL

LYMPHATIC:
CERVICAL NODES: _____NORMAL ____ABNORMAL
SUPRACLAV. NODES: ____NORMAL _____ABNORMAL

ABDOMINAL:
TENDERNESS: _____NONE _____ABNORMAL
LIVER/SPLEEN: _____NORMAL _____ABNORMAL
MASS: _____NONE _____ABNORMAL
HERNIA: _____NONE _____VENTRAL _____INGUINAL
OTHER:_____

RESPIRATORY:
AUSCULTATION: _____CLEAR _____ABNORMAL
RESP. EFFORT: _____NORMAL _____ABNORMAL

MUSCULO-SKELETAL:
GAIT: _____NORMAL ____ABNORMAL
DIGITS/NAILS: _____NORMAL ____CLUBBING/CYAN.

PSYCHIATRIC:
MOOD: _____NORMAL _____ANXIOUS _____DEPRES.
ORIEN.: _____NORMAL X3 _____ABNORMAL
INSIGHT: _____NORMAL _____POOR
MEMORY:_____NORMAL _____POOR