DOCTOR _____ DATE _____ ACCT# _____

CHEST, INFECTIOUS DISEASES AND CRITICAL CARE ASSOCIATES, P.C.

HISTORY AND PHYSICAL

NAME: _____ AGE_____ ☐ MALE ☐ FEMALE

FAMILY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

REASON FOR CONSULTATION/CHIEF COMPLAINT: _____

_____

_____

ALLERGIES: _____ Immunizations: _____

PHARMACY: _____

LIST ALL HOSPITALIZATIONS AND SURGERIES

LIST MEDICATIONS AND DOSAGE
(Please include inhalers, nebulized treatments, patches, herbal supplements, & vitamins)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

CHECK ALL KNOWN MEDICAL CONDITIONS AND DATE DIAGNOSIS MADE. (If yes, please explain)

☐ Y ☐ N Heart Disease _____
☐ Y ☐ N Coronary Artery Disease _____
☐ Y ☐ N CHF _____
☐ Y ☐ N COPD _____
☐ Y ☐ N Rheumatic Fever _____
☐ Y ☐ N Lupus/RA _____
☐ Y ☐ N Seizure _____
☐ Y ☐ N Depression _____
☐ Y ☐ N Anemia _____
☐ Y ☐ N Bleeding Disorder _____
☐ Y ☐ N Sarcoidosis _____
☐ Y ☐ N Immune Deficiency Condition _____
☐ Y ☐ N Tuberculosis _____
☐ Y ☐ N Diabetes _____
☐ Y ☐ N Hepatitis _____
☐ Y ☐ N Colitis _____
☐ Y ☐ N Asthma _____
☐ Y ☐ N Cancer _____
☐ Y ☐ N Reflux _____
☐ Y ☐ N Peptic Ulcer _____
☐ Y ☐ N Hypertension _____
☐ Y ☐ N Blood Transfusion _____
☐ Y ☐ N Kidney Disease _____
☐ Y ☐ N Sleep Disorder _____
☐ Y ☐ N MRSA or VRE _____
☐ Y ☐ N Other _____
☐ Y ☐ N Other _____

MARITAL STATUS: ☐ M ☐ W ☐ D ☐ S

CURRENT OR PREVIOUS OCCUPATION: _____

Check all that apply:

☐ Tire/rubber ☐ Asbestos ☐ Painting ☐ Plastic Manufacturing ☐ Welding ☐ Farming

☐ Disabled From: _____ ☐ Retired From: _____

MILITARY/TRAVEL EXPERIENCES: WHEN: _____ WHERE: _____

Review of Systems

Check ✓ symptoms which you **currently have** or have had and include date/comments

GENERAL
- ☐ Y ☐ N Fever _____
- ☐ Y ☐ N Chills _____
- ☐ Y ☐ N Sweats _____
- ☐ Y ☐ N Weight Gain _____
- ☐ Y ☐ N Weight Loss _____

EYES
- ☐ Y ☐ N Blurred Vision _____
- ☐ Y ☐ N Double Vision _____

EARS, NOSE & THROAT
- ☐ Y ☐ N Hearing Loss _____
- ☐ Y ☐ N Hoarseness _____
- ☐ Y ☐ N Nosebleeds _____
- ☐ Y ☐ N Sinus Problems _____
- ☐ Y ☐ N Bleeding of Gums _____

RESPIRATORY
- ☐ Y ☐ N Shortness of Breath _____
- ☐ Y ☐ N Wheezing _____
- ☐ Y ☐ N Productive Cough-Mucus/Blood _____

CARDIOVASCULAR
- ☐ Y ☐ N Chest Pain _____
- ☐ Y ☐ N Irregular Heartbeat/Palpitation _____
- ☐ Y ☐ N Swelling of Feet/Ankles _____
- ☐ Y ☐ N Painful Legs _____
- ☐ Y ☐ N Leg Clots _____

GASTROINTESTINAL
- ☐ Y ☐ N Appetite Poor/Changed _____
- ☐ Y ☐ N Difficulty Swallowing _____
- ☐ Y ☐ N Bowel Change _____
- ☐ Y ☐ N Constipation _____
- ☐ Y ☐ N Diarrhea _____
- ☐ Y ☐ N Indigestion/reflux _____
- ☐ Y ☐ N Nausea _____
- ☐ Y ☐ N Stomach Pain _____
- ☐ Y ☐ N Vomiting _____
- ☐ Y ☐ N Discoloration of Stools _____

GENITOURINARY
- ☐ Y ☐ N Frequent Urination _____
- ☐ Y ☐ N Painful Urination _____
- ☐ Y ☐ N Difficulty Starting Stream _____
- ☐ Y ☐ N Difficulty Emptying Bladder _____
- ☐ Y ☐ N Kidney Stones _____
- ☐ Y ☐ N Menopausal _____
- ☐ Y ☐ N Pregnant _____

MUSCULOSKELETAL
- ☐ Y ☐ N Pain or Weakness in:
- ☐ Y ☐ N Arms
- ☐ Y ☐ N Back
- ☐ Y ☐ N Feet
- ☐ Y ☐ N Other
- ☐ Y ☐ N Hips
- ☐ Y ☐ N Legs
- ☐ Y ☐ N Hands

NEUROLOGIC
- ☐ Y ☐ N Dizziness
- ☐ Y ☐ N Confusion
- ☐ Y ☐ N Headache
- ☐ Y ☐ N Flushing
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Numbness

SKIN
- ☐ Y ☐ N Itching _____
- ☐ Y ☐ N Skin Sores /Ulcerations _____
- ☐ Y ☐ N Rashes _____
- ☐ Y ☐ N Discoloration _____

PSYCHIATRIC
- ☐ Y ☐ N Anxiety _____
- ☐ Y ☐ N Depression _____
- ☐ Y ☐ N Unusual Stress _____

ENDOCRINOLOGY
- ☐ Y ☐ N Diabetes _____
- ☐ Y ☐ N Excessive Thirst _____
- ☐ Y ☐ N Menopausal _____
- ☐ Y ☐ N Hair Loss _____

HEMATOLOGY, LYMPHATIC
- ☐ Y ☐ N Anemia _____
- ☐ Y ☐ N Bruising _____
- ☐ Y ☐ N Fatigue _____
- ☐ Y ☐ N Swollen Lymph Nodes _____

ALLERGIC/IMMUNOLOGIC
- ☐ Y ☐ N Hayfever _____
- ☐ Y ☐ N Environmental _____
- ☐ Y ☐ N Drug: Specify _____

SLEEP
- ☐ Y ☐ N Snoring _____
- ☐ Y ☐ N Daytime Sleepiness _____
- ☐ Y ☐ N Wake with Shortness of Breath _____

Comments: _____

We at CIC Associates have a commitment to your health and sense of well being. We will evaluate your perception of pain at each office visit. We will use a scale of 0-10 with 0 being no pain and 10 being maximum pain. We will ask what you have been doing to alleviate the pain. We will ask for clarification of where and when you experience pain.

At this time you primary pain is where? _____

What do you take for this pain? _____

Which physician ordered these measures? _____

This is the physician who has primary responsibility to work with you to keep your pain manageable in your life. This is the physician you should notify for changes in your pain control needs. This is also the physician who is responsible for medication changes and refills.