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

Hospital	Reason	Date

LIST MEDICATIONS AND DOSAGE

(Please include inhalers, nebulized treatments, patches, herbal supplements, & vitamins)

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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 GERD ______________________

☐ Y ☐ N Peptic Ulcer ______________________

☐ Y ☐ N Hypertension ______________________

☐ Y ☐ N Blood Transfusion ______________________

☐ Y ☐ N Migraine ______________________

☐ Y ☐ N Sleep Disorder ______________________

☐ 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: ______________________________

HABITS: Have you <u>ever</u> smoked? ☐ Y ☐ N

PACKS PER DAY___________

YEARS SMOKED: __________ QUIT: _________

ALCOHOL: ____________________________

OTHER: ____________________________

NUTRITIONAL STATUS:

Diet: ____

Special Needs: _______________________________

____

FAMILY MEDICAL HISTORY: List medical conditions present or if deceased, list age and cause.

Mother: ______________________ Children: ______________________ Brother: ______________________

Father: ______________________ ______________________ Sister: ______________________

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 Racing Heartbeat ________
- ☐ 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 ________
- ☐ 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 Hips
- ☐ Y ☐ N Back ☐ Y ☐ N Legs
- ☐ Y ☐ N Feet ☐ Y ☐ N Hands
- ☐ Y ☐ N Other

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

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: ____

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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.