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PROMISSORY NOTE

Today's Date: _____
Patient Name: _____ **DOB** ___/___/___
CC: _____ **Allergies:** _____

HPI: _____

ROS: _____

Physical Exam: **VS:** T: _____ BP_____HH_____ RR_____Wt _____Ht _____BMI_____

General: _____
H/E/E/N/T _____
Neck _____
Lungs _____
Heart _____
Back _____
Abdomen _____
Extremities _____
Neuro _____
Skin _____
Genitalia _____

Medication:

Diagnosis: **Evaluation:** **Plan:**

#1 W S I

#2 W S I

#3 W S I

#4 W S I

Patient Educ: ❑ Adv. Directive ❑ Diabetes ❑ Meds ❑ Tobacco/Alcohol ❑ Diet ❑ Exercise ❑ Asthma

Lab + Ancillary

CBC CMP LIPIG LFT TSH UA PSA HgbA1c EKG CXR MAMMO CT ABI

Urine Microalb Stool OB GC/Chlam Pap Smear DEXA Ultrasound

Follow up: _____ Days/Weeks/Months/Years

Provider Signature: _____

HISTORY & PHYSICAL

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MRN #

NAME: **DATE OF BIRTH:** **DATE:**

FAMILY HISORY: IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE:

1) ALCOHOLISM	6) CANCER	11) HEART DISEASE	16) OSTEOPOROSIS
2) ANEMIA	7) DIABETES	12) HYPERTENSION	17) STROKE
3) ASTHMA	8) EPILEPSY	13) KIDNEY DISEASE	18) THYROID
4) ARTHRITIS	9) GLAUCOMA	14) MENTAL ILLNESS	19)
5) BLEEDS EASILY	10) HAYFEVER	15) MIGRAINE	20)

HOSPITAL ADMISSIONS YEAR — ILLNESS OR OPERATION (not including pregnancies)

ALLERGIES
Past:

Present:

LIST ALL MEDICATIONS YOU ARE NOW TAKING: (including Over the Counter)

1)	7)
2)	8)
3)	9)
4)	10)
5)	11)
6)	12)

VACCINE (Year of Last)	TEST/EXAM (Year of Last)
Tetanus / Diptheria	Cholesterol
Influenza	Dental
Pneumococcal	Eye
Hepatitis	Hearing
	Rectal / Stool
	Sigmoidoscopy
	Tuberculosis Skin Test

MEDICAL HISTORY (Check) (✓) and indicate age when you had any of the following symptoms or diseases. MARK (X) for current problems

MAIN PROBLEMS 1) _____ 2) _____ 3) _____

❑ Decreased Hearing	❑ Loss of Appetite - *recent*	❑ Cancer	❑ Phobias	**FEMALES - Please Complete**
❑ Ringing in Ear	❑ Difficulty Swallowing	❑ Diabetes	❑ Mental Illness	Menstrual Flow:
❑ Ear Infections - *frequent*	❑ Indigestion or Heartburn	❑ Thyroid Disease	❑ Chicken Pox	❑ Reg. ❑ Irreg.
❑ Dizzy Spells	❑ Peptic Ulcers	❑ Convulsions / Seizures	❑ Polio	❑ Pain / Cramps
❑ Failing Vision ❑ Eye Pain	❑ Abdominal Pain - *Chronic*	❑ Stroke	❑ Mumps	Days of of Flow _____
❑ Double or Blurred Vision	❑ Gall Bladder Trouble	❑ Tremor / Hands Shaking	❑ Measles	Lengths of Cycle _____
❑ Eye Infections - *frequent*	❑ Juandice / Hepatitis	❑ Muscle Weakness	❑ German Measles	Date _____ of last period
❑ Nose Bleeds - *recurrent*	❑ Change in Bowel Habits	❑ Numbness/Tingling Sensations	❑ Rheumatic Fever	❑ Pain / Bleeding
❑ Sinus Trouble	❑ Diarrhea ❑ Constipation	❑ Headaches - *frequent*	❑ Scarlet Fever	during or after sex
❑ Sore Throat - *frequent*	❑ Diverticulosis	❑ Arthritis / Rheumatism	❑ Tuberculosis	Number of:
❑ Hayfever / Allergies	❑ Crohn's / Colitis	❑ Back Pain - *recurrent*	❑ Herpes	Pregnancies _____
❑ Hoarseness - *prolonged*	❑ Bloody or Tarry Stools	❑ Bone Fracture / Joint Injury	❑ Contact with Blood or	Abortions _____
❑ Pneumonia / Pleurisy	❑ Hemorrhoids	❑ Gout	Body Fluids	Miscarriages _____
❑ Bronchitis / Chronic Cough	❑ Hernia	❑ Osteoporosis	❑ Alcohol _____ oz. per week	Live Births _____
❑ Asthma / Wheezing	❑ Urine Infections - *frequent*	❑ Foot Pain	❑ Smoking _____ cig. per day	Birth Control Method _____
❑ Shorness of Breath:	❑ Blood in Urine	❑ Cold Numb Feet	❑ Number of years	B.C. Pill (Name) _____
❑ on Exertion ❑ Lying Flat	❑ Urination ❑ Overnight>than twice	❑ Rashes	❑ Coffee / Tea	❑ Flushing / Menopause
❑ Chest Pain	❑ Painful ❑ Loss of Control	❑ Hives	# of cups per day _____	Date of last pelvic exams _____
❑ High Blood Pressure	❑ Decrease in Force / Flow	❑ Psoriasis	❑ Advanced Directives	Date of last PAP test _____
❑ Heart Murmur	❑ Kidney Stones	❑ Eczema		❑ Normal ❑ Abnormal
❑ Irregular Pulse Palpitaions	❑ Venereal Disease	❑ Sleeping - *difficulty*	**MALES - Please Complete**	
❑ Swollen Ankles	❑ Urethal Discharge	❑ Nervousness	Date of last prostate exam _____	Date of last breast exam _____
❑ Fainting Spells	❑ Chronic Fatigue	❑ Depression	❑ Normal ❑ Abnormal	
❑ Leg Pain - Walking	❑ Weight Loss - *recent*	❑ Memory Loss		Date of last Mammogram _____
❑ Varicose Veins / Phlebitis	❑ Anemia ❑ Bruise Easily	❑ Moodiness - *excessive*	Date of Last PSA	❑ Normal ❑ Abnormal

SYNOPSIS (OFFICE USE ONLY)

Signature **M.D.**