Washington Health Medical Group

Patient Name:_____

DOB:_____ Age:_____

Occupation:_____

Date:_____

History of Present Illness (main complaints)

What is the main reason for today's visit? Please use the space below (and the back page if necessary) to describe the location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms. Briefly describe the events leading up to the current condition for which you are being seen. If injury, give date of injury.

_____

_____

_____

_____

Does your problem affect your ability to work? ☐Yes ☐No

Other concerns?_____

Do you currently have or have your ever experienced any of the following symptoms?

(Please check all that apply):

Constitutional
- ☐ *No Problems*
- ☐ Fever
- ☐ Night Sweats
- ☐ Difficulty Sleeping
- ☐ Generalized Weakness or Fatigue
- ☐ Unexplained Weight Gain or Loss

Cardiovascular
- ☐ Shortness of breath
- ☐ *No Problems*
- ☐ Irregular Heartbeat
- ☐ Chest Pain

Respiratory
- ☐ Coughing Blood
- ☐ *No Problems*
- ☐ Chronic Cough
- ☐ Wheezing

Gastrointestinal
- ☐ Constipation
- ☐ *No Problems*
- ☐ Bloody Stool
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Black or discolored stool
- ☐ Nausea or Vomiting
- ☐ Abdominal distention
- ☐ Abdominal mass or lumps

Genito-Urinary ☐*No Problems*
- ☐ Burning upon urination
- ☐ Poor bladder control
- ☐ Loss of genital sensation
- ☐ Difficulty starting/ending urinary stream

Musculo-Skeletal
- ☐ *No Problems*
- ☐ Back pain
- ☐ Masses
- ☐ Numbness
- ☐ Swellings
- ☐ Tingling
- ☐ Neck pain
- ☐ Poor coordination
- ☐ Muscle spasms/cramps
- ☐ Loss of control of arms and legs
- ☐ Abnormal arm or leg feelings
- ☐ Change in sensation – inability to feel hot or cold

Psychological
- ☐ Hallucinations
- ☐ *No Problems*
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings

Hematologic/Lymphatic
- ☐ *No Problems*
- ☐ Easy bruising or bleeding
- ☐ Nose Bleeds

Skin and Breast ☐*No Problems*
- ☐ Dry skin ☐Dimpling of skin
- ☐ Body rash or hives
- ☐ Lump on breast(s)
- ☐ Discharge from nipples
- ☐ Problems with wound healing
- ☐ Change in mole appearance
- ☐ Change in color &/or temperature

Neurological
- ☐ Blurry vision
- ☐ *No Problems*
- ☐ Double vision
- ☐ Poor vision
- ☐ Slurred speech
- ☐ Ringing in ear(s)
- ☐ Headache
- ☐ Hoarseness
- ☐ Dizziness
- ☐ Unsteady gait
- ☐ Seizures
- ☐ Facial numbness
- ☐ Loss of hearing (right &/or left)
- ☐ Loss of sense of smell
- ☐ Loss of sense of taste
- ☐ Droopy face &/or eye(s)
- ☐ Difficulty speaking
- ☐ Difficulty swallowing

Endocrine
- ☐ Excessive thirst
- ☐ *No Problems*
- ☐ Cold intolerance
- ☐ Poor appetite
- ☐ Loss of body hair

Have you ever been told you have any of the following?
- ☐ High blood pressure
- ☐ Hernia
- ☐ Emphysema
- ☐ Cancer
- ☐ Diabetes
- ☐ Bronchitis
- ☐ Anemia
- ☐ Asthma
- ☐ Sleep apnea
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Heart condition
- ☐ Chronic bladder infection

Surgery or Hospitalization	Kind of Operation or Illness	When
a)_____	_____	_____
b)_____	_____	_____
c)_____	_____	_____
d)_____	_____	_____

Family History

Relation	Alive/Deceased	Age	Age at death/Cause of Death	Health problems or disorders
Father				
Mother				
Sibling(s)				
Children				
Other: _____				

Have any of your blood relatives had the following diseases? (grandparents, blood-related aunts & uncles) **☑if yes**

□ Heart disease □ Stroke ☐Kidney disease □ Psychiatric disorder □ High Blood pressure
□ Congenital disease □ Emphysema □ Thyroid disease □ Cancer
□ Alzheimer's □ Osteoporosis □ Allergy □ Tuberculosis
□ Diabetes

Social History

Do you have stairs at home? ☐Yes ☐No If yes, are they **INSIDE** or **OUTSIDE**? (circle one)
Do you live alone? ☐Yes ☐No
Education Level: ☐less than grade school ☐grade school ☐middle school ☐high school ☐college ☐graduate school
Employment: ☐Not ☐Full-time ☐Part-time (Hrs/wk _____) ☐Light/modified duty ☐ Retired (date:)_____

Check the descriptions that best illustrate the nature of your work:

☐ prolonged standing hrs/day ☐prolonged waking hrs/day ☐prolonged sitting hrs/day _____
☐ repetitive hand motions ☐ repetitive stooping ☐ repetitive lifting above head/shoulders ☐ repetitive climbing
☐ frequent lifting Maximum weight lifted is/was _____lbs. How often? _____

Smoking/alcohol: Do you smoke? ☐Yes ☐No If yes, Have you smoked in the past? ☐Yes ☐No If yes, pack(s)/day. For _____ how long? When did you quit? Do you drink alcohol? ☐Yes ☐No If yes, drinks/day. If you previously drank, when did you _____ quit? _____ _____

Drugs: Do you use any of the following drugs? ☐Yes ☐No Cocaine - Crack – LSD – Marijuana – Heroin – Other _____
If you previously used drugs, for how long did you do so? When did you quit? _____
Have you ever used prescription medication more often than prescribed or for a reason other than as prescribed? ☐Yes ☐No If you answered "Yes" to the answer above, what medication, for how long, and in what way was it used? _____

Current Medical History / Medications □ List attached

List other medical problems for which you are currently under treatment:

Condition	Treating Physician	Date last seen by MD

List all current medications you are currently taking:

Medications	Why Prescribed?	**Dosage** (how many/how often)

List allergies/sensitivities to medications and the type of reaction: _____

Are you allergic to latex? ☐Yes ☐No ☐Don't Know