# BAYVIEW GENERAL MEDICINE

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## HISTORY & PHYSICAL

DATE _____

NAME_____ MARITAL STATUS___S_M_W_D_SEP_____

ADDRESS_____ CITY_____ M F

STATE_____ ZIP_____ PHONE_____

**FAMILY HISTORY -** ***PLEASE CIRCLE THE NUMBER AND INDICATE WHICH RELATIVE***

***1) EPILEPSY***
***2) MIGRAINE***
***3) STROKE***
***4) DIABETES***
***5) THYROID DISEASE***
***6) HAY FEVER***
***7) ASTHMA***
***8) ANEMIA***
***9) BLEEDING DISORDER***
***10) ARTHRITIS***
***11) HEART DISEASE***
***12) OSTEOPOROSIS***
***13) HYPERTENSION***
***14) LIPID DISORDER***
***15) HEPATITIS***
***16) CANCER***
***17) DEPRESSION***
***18) ALCOHOLISM***

_____
_____
_____
_____

## HOSPITAL ADMISSIONS

_____

**PLEASE LIST ALL CURRENT MEDICATIONS**

_____
_____
_____

**ALLERGIES**

_____
_____
_____

## MEDICAL HISTORY

*MAIN PROBLEM*

_____

_____

| | | | | | |
|---|---|---|---|---|---|
| ○ **Hearing Problems** | ○ **Sinus Trouble** | ○ **Vision Problems** | ○ **Nose Bleeds** | ○ **Hoarseness** | ○ **Dizzy Spells** |
| ○ **Bronchitis/Chronic Cough** | ○ **Pneumonia** | ○ **Sore Throat** | ○ **Asthma/Wheezing** | ○ **Hayfever/Allergies** | ○ **Leg Pain** |
| ○ **Chest Pain** | ○ **High Blood Pressure** | ○ **Irregular Pulse** | ○ **Heart Murmur** | ○ **Varicose Veins** | ○ **Diabetes** |
| ○ **Nausea/ Vomiting** | ○ **Diarrhea/Constipation** | ○ **Urinary Problems** | ○ **Anemia** | ○ **Cancer** | ○ **Fatigue** |
| ○ **Weight Changes** | ○ **Arthritis** | ○ **Rashes** | ○ **Psoriasis** | ○ **Stroke** | ○ **Seizures** |
| ○ **Concentration Problems** | ○ **Headaches** | ○ **Depression** | ○ **Anxiety** | ○ **Mental Illness** | ○ **Phobias** |
| ○ **Thoughts Of Suicide** | ○ **Sleep Problems** | ○ **Sexual Problems** | ○ **Mood Swings** | ○ **Tuberculosis** | |
| ○ **Herpes** | ○ **AIDS/HIV** | ○ **STDs** | ○ **Hepatitis** | | |
| ○ **Smoking- Cig/Day _____ #Years _____** | | ○ **Alcohol _____ Oz. Per Week** | | ○ **Coffee/Tea _____ Cups Per Day** | |

**FEMALES -** *PLEASE COMPLETE*

**NUMBER OF:** **PREGNANCIES** _____ **ABORTIONS** _____
**MISCARRIAGES** _____ **LIVE BIRTHS** _____

**MENSTRUAL FLOW:**

○ REG ○ IRREG ○ PAIN/CRAMPS

DAYS OF FLOW_____ LENGTH OF CYCLE_____ PREGNANT (Y) (N) PLANNING PREGNANCY (Y) (N)

DATE- 1ST DAY OF LAST CYCLE _____

## SOCIAL/ PERSONAL HABITS:

○ SMOKING ○ ALCOHOL ○ CAFFEINE ○ SALT ○ EXERCISE

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## PHYSICAL EXAM

VITAL SIGNS HT_____ WT_____ BP_____ P_____ RR_____ TEMP_____

COMMENTS_____

_____

GENERAL APPEARANCE_____

**PHYSICAL EXAM**

| | | NORMAL | ABNORMA | |
|---|---|---|---|---|
| HEAD & NECK | HEAD/SCALP | ○ | ○ | _____ |
| | LIDS-SCLERA | ○ | ○ | _____ |
| | PUPILS | ○ | ○ | _____ |
| | FUNDI | ○ | ○ | _____ |
| | EARS | ○ | ○ | _____ |
| | NOSE | ○ | ○ | _____ |
| | TEETH/GUMS | ○ | ○ | _____ |
| | PHARYNX | ○ | ○ | _____ |
| | THYROID | ○ | ○ | _____ |
| | NECK GLANDS | ○ | ○ | _____ |
| | CAROTID BRUITS | ○ | ○ | _____ |
| CHEST | CHEST- LUNG | ○ | ○ | _____ |
| | HEART-APEX | ○ | ○ | _____ |
| | HEART SOUND | ○ | ○ | _____ |
| | MURMURS | ○ | ○ | _____ |
| | BREASTS | ○ | ○ | _____ |
| | AXILLARY NODES | ○ | ○ | _____ |
| ABDOM | ABDOMINAL MASSES | ○ | ○ | _____ |
| | ABDOMINAL TENDERNESS | ○ | ○ | _____ |
| | ABDOMINAL BRUITS | ○ | ○ | _____ |

| | | NORMAL | ABNORMA | |
|---|---|---|---|---|
| | HERNIAL RING | ○ | ○ | _____ |
| | INGUINAL NODES | ○ | ○ | _____ |
| EXTREMITIES | PULSES- | | | |
| | FEMORAL | ○ | ○ | _____ |
| | POPLITEAL | ○ | ○ | |
| | POST TIBAL | ○ | ○ | _____ |
| | DORSALIS PEDIS | ○ | ○ | _____ |
| | V.VEINS~EDEMA | ○ | ○ | _____ |
| | CYANOSIS | ○ | ○ | _____ |
| GENIT-URINE | VULVA/ VAGINA | ○ | ○ | _____ |
| | ADNEXAE | ○ | ○ | _____ |
| | CERVIX | ○ | ○ | _____ |
| | UTERUS | ○ | ○ | _____ |
| | PAP TEST (DONE) | ○ | ○ | _____ |
| | GENITALIA- (M) | ○ | ○ | _____ |
| | PROSTATE | ○ | ○ | _____ |
| ANORE | RECTAL | ○ | ○ | _____ |

| | | NORMAL | ABNORMA | |
|---|---|---|---|---|
| JOINTS | NECK | ○ | ○ | _____ |
| | SHOULDERS | ○ | ○ | _____ |
| | ELBOWS | ○ | ○ | _____ |
| | WRISTS | ○ | ○ | _____ |
| | FINGERS | ○ | ○ | _____ |
| | BACK | ○ | ○ | _____ |
| | HIPS | ○ | ○ | _____ |
| | KNEES | ○ | ○ | _____ |
| | ANKLES/FEET | ○ | ○ | _____ |
| NEUROLOGICAL | PARALYSIS | ○ | ○ | _____ |
| | GAIT | ○ | ○ | _____ |
| | MUSCLE ATROPHY | ○ | ○ | _____ |
| | CRANIAL NERVES | ○ | ○ | _____ |
| | TENDON REFLEXES | ○ | ○ | _____ |
| | ROMBERG | ○ | ○ | _____ |
| | BABINSKI | ○ | ○ | _____ |
| | SENSORY | ○ | ○ | _____ |
| | MOTOR | ○ | ○ | _____ |
| DERM | SKIN LESIONS | ○ | ○ | _____ |

| TESTING | | | |
|---|---|---|---|
| | CBC | CHEST XRAY | PROFILES |
| | SMAC | | |
| | CEA | | |
| | CA125/PSA | | |
| | | | |
| | | ECG | |
| | | | |
| | | | |

*COMMENTS*_____

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_____

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