POTOMAC PHYSICIANS, P.A.
ADULT HISTORY AND PHYSICAL EXAM

IMPRINT CARD HERE

NAME: _____

DATE OF BIRTH: _____

CURRENT MEDICAL

Do you have any current medical problems or concerns? _____

_____

_____

Physician's Notes: _____

_____

_____

PAST MEDICAL HISTORY

Illnesses: _____

_____

Surgeries / Hospitalizations: _____

_____

_____

Current Medications: _____

_____

Medication Allergies: _____

_____

_____

VACCINATIONS:

When was your last Tetanus vaccination? _____
If you were born after 1956, have you had your second measles vaccination? _____
Have you had vaccinations against Hepatitis? _____ How many? _____ Against pneumonia? _____
When was your last skin test for tuberculosis? _____ Positive or Negative? _____

GYNECOLOGICAL HISTORY:

Date of your last menstrual period: _____ Are your menses regular? _____
Is there any history of: Abnormal PAP smears? Y ☐ N ☐
Serious Pelvic problems or surgery? _____
When was your last mammogram? _____ Do you examine your breasts? _____ Ever had a lump? _____
Number of Pregnancies: _____ # of Deliveries _____ # of C-sections _____
If you are post-menopausal, and not on hormone replacement therapy, has this option been discussed with you? _____

FAMILY MEDICAL HISTORY NAME: _____ DATE OF BIRTH: _____

	HEART DISEASE	DIABETES	HIGH BLOOD PRESSURE	CANCER (WHAT KIND)	THYROID DISORDERS	BLOOD DISORDERS	GLAUCOMA	STROKES
MOTHER								
FATHER								
MATERNAL GRANDMOTHER								
MATERNAL GRANDFATHER								
PATERNAL GRANDMOTHER								
PATERNAL GRANDFATHER								
BROTHER OR SISTER								
BROTHER OR SISTER								
BROTHER OR SISTER								
BROTHER OR SISTER								
OTHER RELATIVES								

DO YOU HAVE ANY OTHER MEDICAL OR MENTAL HEALTH PROBLEMS IN YOUR FAMILY? _____

_____

SOCIAL HISTORY:

SMOKING HISTORY: (HOW MUCH FOR HOW LONG) _____

ALCOHOL HISTORY: (HOW OFTEN, HOW MUCH) _____

DRUG HISTORY: (WHICH DRUGS, HOW MUCH) _____

DO YOU USE SEAT BELTS? _____

MARITAL STATUS: _____

CHILDREN: _____

PRESENT OCCUPATION: _____

HISTORY OF EXPOSURE TO DANGEROUS SUBSTANCES: _____

HISTORY OF HIGH RISK SEXUAL PRACTICES: _____

EXERCISE: _____

_____

NAME: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS

DO YOU HAVE ANY SIGNIFICANT? (CHECK ONE OR DESCRIBE)

GENERAL: ☐ Weight Loss/Gain ☐ Fevers ☐ Night Sweats
☐ Other: _____

EYES: ☐ Change in Vision
☐ Other: _____

EARS: ☐ Decreased Hearing ☐ Ear Pain
☐ Other: _____

NOSE: ☐ Sinus Problems ☐ Allergies
☐ Other: _____

THROAT: ☐ Frequent Sore Throats ☐ Persistant Hoarseness
☐ Other: _____

NECK: ☐ Frequent Neck Pain ☐ Arm Numbness, Tingling ☐ Thyroid Problems
☐ Other: _____

BACK: ☐ Frequent Back Pain ☐ Leg Pain, Numbness
☐ Other: _____

RESPIRATORY: ☐ Chronic Cough ☐ Wheezing ☐ Shortness of Breath
☐ Other: _____

CARDIOVASCULAR: ☐ Exertional Chest Pain ☐ Palpitations ☐ Swelling of Legs
☐ Other: _____

GASTROENTEROLOGIC: ☐ Nausea/Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn ☐ Blood or pain w/BM
☐ Other: _____

GENITOURINARY: ☐ Urinary Problems ☐ Menstrual Problems ☐ Sexual Problems
☐ Other: _____

NEUROLOGIC: ☐ Severe Headaches ☐ Dizzy Spells ☐ Seizures
☐ Other: _____

MUSCULOSKELETAL: ☐ Unusual Joint Pains ☐ Unusual Muscle Pains
☐ Other: _____

DERMATOLOGIC: ☐ Skin Lesions ☐ Rashes
☐ Other: _____

HEMATOLOGIC: ☐ History of Anemia ☐ Clotting Disorder ☐ Sickle Cell
☐ Other: _____

ENDOCRINOLOGIC: ☐ Unusual Thirst ☐ Cold or Heat Intolerance ☐ Discharge from Breasts
☐ Other: _____

PSYCHOLOGIC: ☐ Depression ☐ Anxiety
☐ Other: _____

NAME: _____ DATE OF BIRTH: _____

PHYSICAL EXAM

HEIGHT _____ BLOOD PRESSURE _____ RESPIRATORY RATE _____

WEIGHT _____ PULSE _____ TEMPERATURE _____

GENERAL
APPEARANCE _____

_____

SKIN _____ HEAD _____

EYES _____ ENT _____

NECK _____ BACK _____

CHEST _____ LUNGS _____

HEART _____ BREASTS _____

ABDOMEN _____ RECTAL _____

GENITALS _____ LYMPHATICS _____

EXTREMITIES _____ PVS _____

NEURO _____ PSYCHOLOGIC _____

PHYSICIAN'S ASSESSMENT:

1.

2.

3.

4.

PLAN:

PROVIDER SIGNATURE _____ DATE: _____