Medical Form

Date _____ Name _____

Allergies _____ DOB _____ Age _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____ LMP _____

Problems Addressed	**Medications**	**Rxs Written**

Risk factors reviewed

1. Diet
2. Exercise
3. Safety (seat belts, smoke detectors, firearms, violence)
4. Smoking
5. Alcohol and other drugs
6. STDs/Contraception
7. Advanced directive

Disease prevention and recommendations

1. Stroke and coronary disease (BP, cholesterol, weight, stress, aspirin 81 mg/day)
2. Cancer (diet, vitamins C 500 mg and E 400 units)
3. Osteoporosis (exercise, calcium 1500 mg, vitamin D 400 units, estrogen)
4. Viruses and colds (wash hands, vitamin C 500-1000 mg, Echinacea, fluids, zinc)
5. Other _____

Health maintenance (enter date, or ✓ if done today, or WS for "will schedule")

1. Immunizations Td _____ Flu _____ Pneumovax _____ Hep.B _____ Hep.C _____ Varicella _____
2. Lab CBC _____ Chem _____ TSH _____ PSA _____ Lipid profile _____
   U/A _____ Hemocults _____ Other _____
3. Pap _____ GC/CT _____
4. Mammogram _____ Bone Density _____
5. Flex. Sig. _____ Treadmill _____ Ophthalmology _____

Other Recommendations/Referrals

Follow up _____ Next Physical _____

[**Dr. Name**] [**Dr. Name**] [**Dr. Name**] [**Dr. Name**] [**Dr. Name**] [**ARNP Name**] [**ARNP Name**]

Date _____ Name _____

DOB _____ Age _____

Additional history discussed

☐ Update Family History ☐ Update Surgeries

ROS

☐ HEENT	☐ Gastrointestinal	☐ General
☐ Cardiovascular	☐ Genitourinary	☐ Psychiatric
☐ Respiratory	☐ Neuromuscular	☐ Derm.

Physical exam

Head	_____	Heart	_____	Extremities	_____
Eyes	_____	Lungs	_____		
Ears	_____	Breasts	_____	Scrotum	_____
Nose	_____	Abdomen	_____	Penis	_____
Throat	_____	Vulva	_____	Hernia?	_____
Thyroid	_____	Vagina	_____	Prostate	_____
Nodes	_____	Cervix	_____		
Carotids	_____	Uterus	_____	Rectum	_____
Skin	_____	Adnexae	_____		