



ORCHARD MEDICAL GROUP

HOSPITALIZATION OR SURGERY

DATE	REASON	DATE	REASON

HISTORY & PHYSICAL

NAME _____
 DATE _____ SS# _____
 ADDRESS _____
 OCCUPATION _____ PHONE (HOME) _____
 (WORK) _____ DATE OF BIRTH _____
 CHIEF COMPLAINT _____
 INSURANCE# _____

DRUG ALLERGIES

MEDICATIONS

VACCINE	YEAR OF LAST	VACCINE	YEAR OF LAST	TEST/EXAM	YEAR OF LAST	TEST/EXAM	YEAR OF LAST
TETANUS	_____	PNEUMONIA	_____	RECTAL/STOOL	_____	TUBERCULOSIS	_____
FLU	_____	OTHER	_____	CHOLESTEROL	_____	OTHER	_____

MEDICAL HISTORY

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> ABDOMINAL PAIN - CHRONIC | <input type="checkbox"/> GALL BLADDER TROUBLE | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> POLIO <input type="checkbox"/> MUMPS |
| <input type="checkbox"/> ALLERGIES/HAYFEVER | <input type="checkbox"/> GOUT | <input type="checkbox"/> PROSTATE DISEASE | <input type="checkbox"/> MEASLES <input type="checkbox"/> RUBELLA <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ANEMIA <input type="checkbox"/> BRUISE EASILY | <input type="checkbox"/> HAIR LOSS | <input type="checkbox"/> PSORIASIS <input type="checkbox"/> ECZEMA | <input type="checkbox"/> SCARLET FEVER <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> HERPES |
| <input type="checkbox"/> ANKLES - SWOLLEN | <input type="checkbox"/> HEADACHES - FREQUENT | <input type="checkbox"/> RASHES <input type="checkbox"/> HIVES | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> APPETITE - LOSS OF | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> SEXUAL/MENSTRUAL DYSFUNCTION | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> ARTHRITIS/RHEUMATISM | <input type="checkbox"/> HEMORRHOIDS | <input type="checkbox"/> SINUS TROUBLE | |
| <input type="checkbox"/> ASTHMA/WHEEZING | <input type="checkbox"/> HERNIA | <input type="checkbox"/> STOOLS - BLOODY OR TARRY | Females - Please Complete |
| <input type="checkbox"/> BACK PAIN - RECURRENT | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> STROKE | PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> BONE FRACTURE/JOINT INJURY | <input type="checkbox"/> INDIGESTION OR HEARTBURN | <input type="checkbox"/> SWALLOWING DIFFICULTY | PLANNING PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> BOWEL HABITS - CHANGE IN | <input type="checkbox"/> INFECTIONS - FREQUENT | <input type="checkbox"/> TETANUS | Menstrual Flow: |
| <input type="checkbox"/> BRONCHITIS/CHRONIC COUGH | <input type="checkbox"/> JAUNDICE/HEPATITIS | <input type="checkbox"/> THROAT - SORE - FREQUENT | <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain/Cramps |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> KIDNEY STONES | <input type="checkbox"/> THYROID DISEASE | Days of Flow _____ Length of Cycle _____ |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> LACTOSE INTOLERANCE | <input type="checkbox"/> TREMOR/HANDS SHAKING | Date-1st day of last period _____ |
| <input type="checkbox"/> CONVULSIONS/SEIZURES | <input type="checkbox"/> LEG PAIN - WALKING | <input type="checkbox"/> ULCERS - PEPTIC | <input type="checkbox"/> Pain/Bleeding during or after sex |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> MEMORY LOSS | <input type="checkbox"/> URETHRAL DISCHARGE | Number of: |
| <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> MENTAL ILLNESS | <input type="checkbox"/> URINATION - OVERNIGHT > THAN TWICE | _____ Pregnancies _____ Abortions |
| <input type="checkbox"/> DIPHThERIA | <input type="checkbox"/> MOODINESS - EXCESSIVE | <input type="checkbox"/> DECREASE IN FORCE/FLOW | _____ Miscarriages _____ Live Births |
| <input type="checkbox"/> DIVERTICULOSIS <input type="checkbox"/> CROHN'S/COLITIS | <input type="checkbox"/> MUSCLE WEAKNESS | <input type="checkbox"/> PAINFUL <input type="checkbox"/> LOSS OF CONTROL | Birth Control Method _____ |
| <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> NAUSEA/VOMITING - PERSISTENT | <input type="checkbox"/> URINE - BLOOD IN | B.C. Pill (Name) _____ |
| <input type="checkbox"/> EAR INFECTIONS - FREQUENT | <input type="checkbox"/> NERVOUSNESS <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> VARICOSE VEINS/PHLEBITIS | <input type="checkbox"/> Flushing/Menopause |
| <input type="checkbox"/> EAR - RINGING IN | <input type="checkbox"/> NOSE BLEEDS | <input type="checkbox"/> VENEREAL DISEASE | Date of Last PAP Test _____ |
| <input type="checkbox"/> EYE INFECTIONS | <input type="checkbox"/> NUMBNESS/TINGLING SENSATIONS | <input type="checkbox"/> VISION - FAILING | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> FATIGUE - CHRONIC | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> WEIGHT LOSS - RECENT | Date of Last Mammogram _____ |
| <input type="checkbox"/> FOOT PAIN <input type="checkbox"/> COLD NUMB FEET | <input type="checkbox"/> PHOBIAS | | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |

FAMILY HISTORY

	FATHER	MOTHER	CHILDREN	SIBLINGS	FATHER'S PARENTS	MOTHER'S PARENTS		FATHER	MOTHER	CHILDREN	SIBLINGS	FATHER'S PARENTS	MOTHER'S PARENTS
ALCOHOLISM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MIGRAINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OSTEOPOROSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY/CONVULSIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	THYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAIR LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER	_____	_____	_____	_____	_____	_____
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							

HABITS

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> ALCOHOL: TYPE _____
AMOUNT _____ | <input type="checkbox"/> DIET: SALT INTAKE _____
FAT INTAKE _____
OTHER _____ | <input type="checkbox"/> SLEEP: DIFFICULTY FALLING ASLEEP _____
CONTINUITY DISTURBANCES _____
EARLY MORNING AWAKENING _____
DAYTIME DROWSINESS _____
OTHER _____ | <input type="checkbox"/> SMOKE: PACKS DAILY _____
HOW LONG _____
INTERESTED IN STOPPING? _____ |
| <input type="checkbox"/> COFFEE: CUPS DAILY _____
OTHER CAFFEINE _____ | <input type="checkbox"/> EXERCISE ROUTINE: _____ | | |