Northeast Georgia
PHYSICIANS GROUP

TRAUMA AND ACUTE CARE

FRONT

Name: _____ **DOB:** _____ **Patient Age:** _____ **Today's Date:** _____

Physician: _____ **Referring Physician:** _____

What are we seeing you for today? _____

What symptoms are you having? _____

Name of your preferred pharmacy? _____

Surgical History:

Have you ever had a colonoscopy? ❑ Yes ❑ No When? _____

Have you had any operations in the past? ❑ Yes ❑ No

If yes, please list: _____

Medical History: (Please check any applicable)

❑ Aneurysm	❑ Pneumonia	❑ Peptic Ulcer Disease
❑ Heart Attack	❑ COPD	❑ Kidney Stones
❑ High Blood Pressure	❑ Asthma	❑ Thyroid Disease
❑ Stroke	❑ Lung Cancer	❑ Prostate Cancer
❑ Congestive Heart Failure	❑ Tuberculosis	❑ Breast Cancer
❑ Mitral Valve Prolapse	❑ Hepatitis A, B, C	❑ Skin Cancer
❑ High Cholesterol	❑ Cirrhosis of he Liver	❑ Depression
❑ Colon Cancer	❑ Hiatal Hernia / GERD	❑ Seizures
❑ Colon Polyps	❑ Diabetes: ❑ Type I ❑ Type II	

Other problems not listed: _____

Do you take:

Aspirin: ❑ Yes ❑ No **Arthritis Medication**: ❑ Yes ❑ No **Coumadin (Warfarin)**: ❑ Yes ❑ No **Plavix**: ❑ Yes ❑ No

Are you taking any medications daily? ❑ Yes ❑ No ***If yes, please List Medications along with Dosage:***

_____

_____

_____

_____

_____

Are you allergic to any medications? ❑ Yes ❑ No **Are you allergic to any Latex?** ❑ Yes ❑ No

If yes, please list along with reactions: _____

_____

Family History:

Mother: ❑ Alive ❑ Deceased Cause of death: _____

Father: ❑ Alive ❑ Deceased Cause of death: _____

Any family history of: (Immediate Family)

Cancer: ❑ Yes ❑ No If yes, please list relation and type of cancer: _____

Diabetes: ❑ Yes ❑ No If yes, relation: _____

Strokes: ❑ Yes ❑ No If yes, relation: _____

Heart Attacks: ❑ Yes ❑ No If yes, relation: _____

Social History:

❑ Married ❑ Divorced ❑ Widowed ❑ Single

# of Children: _____ **Occupation:** _____

Tobacco History: ❑ Current Use ❑ Previous Use ❑ Never Used # of years used: _____ # of years quit: _____

Alcohol Use: ❑ Yes ❑ No If yes, frequency: _____

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BACK

Name: _____ **DOB:** _____ **Physician:** _____

PLEASE ANSWER ALL QUESTIONS

Are you **currently** experiencing any of the following?

General History:

Weight Gain	❑ Yes	❑ No
Weight Loss	❑ Yes	❑ No
Increased Fatigue	❑ Yes	❑ No
Trouble Sleeping	❑ Yes	❑ No
Increased Appetite	❑ Yes	❑ No

Ear/Nose/Throat:

Hoarseness	❑ Yes	❑ No
Choking	❑ Yes	❑ No
Sore Throat	❑ Yes	❑ No
Ear Aches	❑ Yes	❑ No
Sinus Drainage	❑ Yes	❑ No

Respiratory:

Difficult Breathing	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No
Cough	❑ Yes	❑ No
Mucous	❑ Yes	❑ No
Blood	❑ Yes	❑ No

Cardiac:

Chest Pains	❑ Yes	❑ No
Palpitations	❑ Yes	❑ No
Swollen Feet	❑ Yes	❑ No
Short of Breath (when lying flat)	❑ Yes	❑ No
Cardiac Cath.	❑ Yes	❑ No
If yes, when? _____		
Cardiac Stress test	❑ Yes	❑ No
If yes, when? _____		

Neurologic:

Muscle Weakness	❑ Yes	❑ No
Numbness	❑ Yes	❑ No
Seizures	❑ Yes	❑ No
Memory Loss / Dementia	❑ Yes	❑ No

Breast: (Female)

Breast Mass	❑ Yes	❑ No
Nipple Discharge	❑ Yes	❑ No
If yes, what color? _____		
Breast pain / Tenderness	❑ Yes	❑ No
Changes in appearance	❑ Yes	❑ No
Family history of breast cancer	❑ Yes	❑ No
If yes, when? _____		
Cardiac Stress test	❑ Yes	❑ No
If yes, when? _____		

OB/GYN: (Female)

Date of last period:	_____	
Age of Menstruation:	_____	
Menopause	❑ Yes	❑ No

Vascular:

Mini-Strokes / TIA's	❑ Yes	❑ No
Pain in legs when walking	❑ Yes	❑ No
Cramping in legs	❑ Yes	❑ No

Gastrointestinal:

Heart Burn	❑ Yes	❑ No
Regurgitation	❑ Yes	❑ No
Difficulty Swallowing	❑ Yes	❑ No
Abdominal Pain	❑ Yes	❑ No
Nausea	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No
Bloating	❑ Yes	❑ No
Early feeling of fullness	❑ Yes	❑ No
Rectal Bleeding	❑ Yes	❑ No
Constipation	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Change in size / color of stool	❑ Yes	❑ No
# of bowel movements per day:	_____	

Genitourinary:

Difficulty Urinating	❑ Yes	❑ No
Urinating frequently at night	❑ Yes	❑ No
Blood in Urine	❑ Yes	❑ No
Loss of Bladder Control	❑ Yes	❑ No
Weak Stream	❑ Yes	❑ No

Endocrine:

Glandular or hormone problem	❑ Yes	❑ No
Thyroid Disease	❑ Yes	❑ No
Excessive Thirst or Urination	❑ Yes	❑ No
Heat or cold intolerance	❑ Yes	❑ No

Hematologic / Lymphatic:

Slow to heal after cuts	❑ Yes	❑ No
Easily bruise or bleed	❑ Yes	❑ No
Anemia	❑ Yes	❑ No
Phlebitis	❑ Yes	❑ No
Past transfusion	❑ Yes	❑ No
Enlarged glands	❑ Yes	❑ No

Allergic / Immunologic:

History of skin reaction to: _____

Penicillin or other antibiotics	❑ Yes	❑ No
Morphine or other narcotics	❑ Yes	❑ No
Novocaine or other anesthetics	❑ Yes	❑ No
Tetanus or other serums	❑ Yes	❑ No
Iodine or other antiseptic	❑ Yes	❑ No

Known food allergies: _____

Patient Signature: _____ **Reviewed by:** _____