Mid Ohio Surgical Associates, Inc.
Patient Medical Form

❑ Post-Op Visit ❑ New Office Visit ❑ Consultation Physician: ❑ Non-scheduled, walk-in patient.
Overbooked w/ Dr._____'s approval.

HISTORY - Completed by Patient

Reason for your visit today: _____

REVIEW OF SYSTEMS ____P = 1 ____E = 2 - 9 ____C = 10

Please indicate if you are currently having or had recent problems with:

Body System	Yes	No	Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No	Symptom
General:	❑	❑	Fever	❑	❑	Chills	❑	❑	Weight Change	❑	❑	Diet Change
Skin:	❑	❑	New lumps	❑	❑	Ulcers	❑	❑	Change in mole	❑	❑	Last mammogram
Ears, Nose, Throat:	❑	❑	Hearing	❑	❑	Nose bleeds	❑	❑	Swallowing problems			____/____/____
Eyes, Head:	❑	❑	Severe headaches	❑	❑	Vision loss	❑	❑	Change in vision	❑	❑	Change in voice
Lungs (Breathing):	❑	❑	Severe shortness of breath	❑	❑	Recent change in sputum	❑	❑	Coughing up blood			
Heart (Circulation):	❑	❑	Swelling of ankles	❑	❑	Pain in legs with walking	❑	❑	Irregular pulse	❑	❑	Chest pain
Stomach, Intestines:	❑	❑	Abdominal pain	❑	❑	Nausea or vomiting	❑	❑	Constipation	❑	❑	Diarrhea
Urinary System:	❑	❑	Blood in urine	❑	❑	Pain with urination				❑	❑	Blood in stool
Thyroid (Endocrine):	❑	❑	Heat intolerance	❑	❑	Cold intolerance	❑	❑	Weakness			
Neurologic System:	❑	❑	Seizures	❑	❑	Numbness	❑	❑	Easy Bruising			
Psychiatric:	❑	❑	Depression	❑	❑	Anxiety						
Blood (Hematology):	❑	❑	Anemia	❑	❑	Prolonged bleeding						
Other:												

PAST HISTORY ____P = 1 ____C = 3

Medical and Surgical

Please indicate if you have or ever had any of the following medical problems:

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Coronary artery blockages	❑	❑	Diabetes	❑	❑	Cancer (what type?)	❑	❑	TB (had or vaccinated for)
❑	❑	Congestive heart failure	❑	❑	High blood pressure	❑	❑	Stomach ulcers	❑	❑	Heart attack
❑	❑	Emphysema	❑	❑	Heart arrhythmias	❑	❑	Stroke	❑	❑	Bronchitis (chronic)
❑	❑	Hepatitis	❑	❑	TIA	❑	❑	Asthma	❑	❑	HIV infection or AIDS

List any other medical problems for which you are seeing a doctor: _____

_____

Please list **all** your prior surgeries and include the approximate date: _____

_____

SOCIAL HISTORY

Marital Status: ❑ single ❑ divorced ❑ married ❑ widow/widower

Current occupation: _____

Are you currently smoking?_____How many years have or had you smoked?_____How many packs a day did or do you smoke? _____

Do you drink alcohol?_____How much do you drink?_____

FAMILY HISTORY Is there a family history of any of the following diseases?

Yes	No		Yes	No	
❑	❑	Heart Attack	❑	❑	Cancer (what kind)
❑	❑	Strokes	❑	❑	Other:

History - Completed by Physician

HISTORY OF PRESENT ILLNESS (Location, Quality, Timing, Severity, Duration, Context, Modifying Factors, Assoc. signs/symptoms)
___ B = 1-3 ____ E = 4 or status of 3 chronic/inactive

Comment here or include in dictation on reverse side.

Exam

EXAM LEVEL _____PF = 1 - 5 ____EPF = 6 - 11 ____D = 12 ____C = 2 from 9 systems

1. General Right BP _____ Left BP _____ Pulse _____ Resp _____ Weight _____ Height _____
Appearance is: ❑ Well Developed ❑ ill appearing ❑ Cachectic ❑ Obese ❑ Other

	Normal	Abnormal	
2. Eyes			
Conjunctiva / lids	❑	❑	_____
PERRLA	❑	❑	_____
3. ENT			
External appearance	❑	❑	_____
Hearing	❑	❑	_____
Nasal mucosa, septum	❑	❑	_____
Lips, teeth, gums	❑	❑	_____
Oropharynx	❑	❑	_____
4. Neck			
Appearance, masses	❑	❑	_____
Thyroid	❑	❑	_____
5. Respiratory			
Respiratory effort	❑	❑	_____
Breath Sounds	❑	❑	_____
6. Cardiovascular			
Palpatation of heart (size, PMI)	❑	❑	_____
Heart sounds, murmur	❑	❑	_____
Carotid arteries (bruit)	❑	❑	_____
Abdominal aorta (size)	❑	❑	_____
Femoral pulses	❑	❑	_____
Pedal pulses	❑	❑	_____
Extremities (no edema)	❑	❑	_____
7. Chest (breasts)			
Inspection of breasts	❑	❑	_____
Palpatation of breasts & axillae	❑	❑	_____
8. Gastrointestinal (abdomen)			
Tenderness / masses	❑	❑	_____
Liver / Spleen	❑	❑	_____
Hernia present	❑	❑	_____
Anus, perineum, rectum	❑	❑	_____
Hemoccult	❑	❑	_____
9. GU			
Scrotal contents	❑	❑	_____
Penis	❑	❑	_____
Rectal exam / prostate	❑	❑	_____
10. Lymphatics			
Neck	❑	❑	_____
Axillae	❑	❑	_____
Groin	❑	❑	_____
Other:	❑	❑	_____
11. Musculoskeletal			
Gait and station	❑	❑	_____
Digits and nails	❑	❑	_____
Joints / bones / muscles	❑	❑	_____
RUE	❑	❑	_____
LUE	❑	❑	_____
RLE	❑	❑	_____
LLE	❑	❑	_____
12. Skin			
Inspection	❑	❑	_____
Palpation	❑	❑	_____
13. Neurologic			
Cranial nerves	❑	❑	_____
Deep tendon reflexes	❑	❑	_____
Sensation	❑	❑	_____
14. Psychiatric			
Oriented X 3	❑	❑	_____
Mood and affect	❑	❑	_____

CLINICAL DATA_____

- ❑ Prescription Written
- ❑ Labs reviewed (1)
- ❑ X-rays ordered (1)
- ❑ Radiographs/Labs reviewed (2)
- ❑ Labs ordered (1)
- ❑ Letter dictated (1)
- ❑ Records requested (1)
- ❑ Physician phone call (1)
- ❑ Consult letter reviewed (1)
- ❑ Non-invasive proc. ordered (1)
- ❑ Radiographic reports reviewed (1)
- ❑ Invasive procedure ordered (1)
- ❑ Medical records reviewed (2)

Number of Diagnosis/Treatment Options ❑ I ❑ 2 ❑ 3 ❑ 4(max)

- ❑ Self-limited or minor problem (stable, improve, or worsened)
- ❑ Est. Problem: stable or improved
- ❑ Est. Problem: worsening (max 2 choices)
- ❑ New Problem: no work-up planned
- ❑ New Problem: addl work-up planned (max. 1 choice)

Assessment/Treatment Plan

Physician Signature _____

Comment here or include in dictation