

RAPIDES TRAUMA AND CRITICAL CARE SERVICE
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History and Physical

Patient Name _____ Date _____ Ref _____
Doctor _____ Age _____ Family Doctor _____
Date of Birth _____ Reason for today's visit: _____

History (to be completed by physician) _____

Allergies/Reactions: _____

Past Medical History (Please circle one. If yes, please explain.) Heart Disease Yes
No _____ Diabetes Yes
No _____ High Blood Pressure Yes No
_____ Lung Disease Yes
No _____ Kidney Disease Yes
No _____ Liver Disease Yes
No _____ Cancer Yes
No _____ Bleeding Disorder Yes
No _____ Other Yes

Past Surgical History Operation Date _____

Family History (Please circle one. If Yes, please explain) Cancer Yes
No _____ If yes, specify family member and type
_____ Heart Disease Yes
No _____ Diabetes Yes
No _____ Bleeding Disorder Yes
No _____ Other

Social History: Marital Status _____ Living Arrangements _____
Employment _____ Level of education _____ Have you
smoked? Yes No
Packs per day _____ Number of years smoked: _____ Quit? Yes
No If yes, for how long? _____ Have you used alcohol? Yes
No

How much? _____ Quit? Yes No If yes, for how long? _____

Present Medications (including herbs and vitamins): Medication Dose
How often

Review of Symptoms (Please circle one. If yes, please explain.)

GENERAL: Recent weight loss Recent fever Fatigue Loss of appetite

EYES: Double vision Recent change in vision Do you wear glasses/contacts Pain

EARS,NOSE,MOUTH,THROAT Ear drainage Loss of hearing Non-healing ulcers in mouth

Nose bleeds Dizziness Sore throat

CARDIOVASCULAR: Chest pain Shortness of breath with mild

Exertion Skipped beats of heart Prior heart attack/stroke Leg pain when walking

RESPIRATORY: Cough Coughing up blood Wheezing Recent pneumonia

GASTROINTESTINAL: Frequent abdominal pain Black stools Yes No Yes No Yes

No Yes No

Yes No Yes No Yes No Yes No

Yes No Yes No Yes No Yes No Yes No Yes No

Yes No

Yes No Yes No Yes No Yes No

Yes No Yes No Yes No Yes No

Yes No Yes No Blood in stools History of ulcers,gallbladder,liver

**Pancreas disease Difficulty swallowing Frequent vomiting Diarrhea
Constipation Yes No**

Yes No Yes No Yes No Yes No Yes No

Most recent colonoscopy, if done _____

**GENITOURINARY: Blood in urine Frequent urinary tract infections History kidney stones
Difficulty urinating Yes No Yes No Yes No Yes No**

Unexplained change in menstrual cycles Yes No

Number of pregnancies Number of births Is there any chance that you pregnant?

**MUSCULOSKELETAL: History of broken bones Recent onset of new bone/joint pain
Arthritis Foot ulcers**

**NEUROLOGICAL: Seizure disorder Unexplained headaches Temporary loss feeling/use of one
extremity Speech loss/difficulty speaking Temporary loss of vision**

**HEMOTOLOGICAL: History of bleeding disorder History of sickle cell anemia
Recent fever or infections Hepatitis/HIV**

**BREASTS: Any lumps Nipple drainage Skin changes Pain Mammograms within past year Close
relative with breast cancer History hormone therapy Yes No Yes No Yes No Yes No**

Yes No Yes No

Yes No Yes No Yes No

Yes No Yes No Yes No Yes No

Yes No Yes No Yes No Yes No Yes No Yes No Yes No

Patient Signature: _____ Date _____ Physician

Signature: _____ Date _____