# Princeton Surgical Specialists, P.C.

## HISTORY & PHYSICAL REVIEW

| NAME | DATE OF BIRTH | REFERRING DOCTOR |
|---|---|---|
| | | |

| REASON FOR VISIT | CHRONIC PROBLEMS |
|---|---|
| | |

VITALS

**PLEASE LIST ALL MEDICATIONS YOU CURRENTLY TAKE, INCLUDING THOSE PRESCRIBED BY OTHER PHYSICIANS, AND OVER-THE COUNTER MEDICINES**

| NAME OF MEDICINE | DOSAGE | HOW OFTEN PER DAY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

PHARMACY NAME

PHARMACY PHONE #

**ALLERGIES:** _____

## REVIEW OF SYSTEMS - PLEASE CHECK EACH ITEM YES OR NO AS THEY RELATE TO YOUR HEALTH

### CONSTITUTION

| | | |
|---|---|---|
| Chills | ❑ Yes | ❑ No |
| Decreased Activity | ❑ Yes | ❑ No |
| Decreased Appetite | ❑ Yes | ❑ No |
| Fatigue | ❑ Yes | ❑ No |
| Increased Appetite | ❑ Yes | ❑ No |
| Insomnia | ❑ Yes | ❑ No |
| Irritability | ❑ Yes | ❑ No |
| Lethargy | ❑ Yes | ❑ No |
| Feeling Tired | ❑ Yes | ❑ No |
| Night Sweats | ❑ Yes | ❑ No |
| Weakness | ❑ Yes | ❑ No |
| Weight Gain | ❑ Yes | ❑ No |
| Weight Loss | ❑ Yes | ❑ No |

### HEENT

| | | |
|---|---|---|
| Headache | ❑ Yes | ❑ No |
| Dry Eyes | ❑ Yes | ❑ No |
| Sensation | ❑ Yes | ❑ No |
| Eye Redness | ❑ Yes | ❑ No |
| Itchy Eyes | ❑ Yes | ❑ No |
| Eye Pain | ❑ Yes | ❑ No |
| Vision Loss | ❑ Yes | ❑ No |
| Glasses/Contacts | ❑ Yes | ❑ No |
| Fullness/Ringing | ❑ Yes | ❑ No |
| Vertigo | ❑ Yes | ❑ No |
| Nasal Drainage | ❑ Yes | ❑ No |
| Congestion | ❑ Yes | ❑ No |
| Sinusitis | ❑ Yes | ❑ No |
| Sneezing | ❑ Yes | ❑ No |
| Change in Taste | ❑ Yes | ❑ No |
| Cold Sores | ❑ Yes | ❑ No |
| Trouble Swallowing | ❑ Yes | ❑ No |
| Hoarseness | ❑ Yes | ❑ No |
| Lump in Throat | ❑ Yes | ❑ No |
| Sore Tongue | ❑ Yes | ❑ No |
| Snoring | ❑ Yes | ❑ No |
| Tooth Pain | ❑ Yes | ❑ No |

### RESPIRATORY

| | | |
|---|---|---|
| Accelerated Respirations | ❑ Yes | ❑ No |
| Cough | ❑ Yes | ❑ No |
| Frequent Upper Respiratory Infections | ❑ Yes | ❑ No |
| Snoring | ❑ Yes | ❑ No |
| Wheezing | ❑ Yes | ❑ No |
| Coughing Up Blood | ❑ Yes | ❑ No |
| Turning Blue | ❑ Yes | ❑ No |

### CARDIAC

| | | |
|---|---|---|
| Chest Pain | ❑ Yes | ❑ No |
| Edema | ❑ Yes | ❑ No |
| Irregular Heart Beat | ❑ Yes | ❑ No |
| Syncope | ❑ Yes | ❑ No |

### GI

| | | |
|---|---|---|
| Abdominal Mass | ❑ Yes | ❑ No |
| Abdominal Pain | ❑ Yes | ❑ No |
| Bloating | ❑ Yes | ❑ No |
| Blood in Stool | ❑ Yes | ❑ No |
| Change in Bowel Habits | ❑ Yes | ❑ No |
| Constipation | ❑ Yes | ❑ No |
| Diarrhea | ❑ Yes | ❑ No |
| Fecal Incontinence | ❑ Yes | ❑ No |
| Gas | ❑ Yes | ❑ No |
| Heartburn | ❑ Yes | ❑ No |
| Hemorrhoids | ❑ Yes | ❑ No |
| Jaundice | ❑ Yes | ❑ No |
| Nausea | ❑ Yes | ❑ No |
| Rectal Bleeding | ❑ Yes | ❑ No |
| Reflux | ❑ Yes | ❑ No |
| Vomiting | ❑ Yes | ❑ No |
| Clay Colored Stool | ❑ Yes | ❑ No |
| Wheezing | ❑ Yes | ❑ No |

### GENITOURINARY

| | | |
|---|---|---|
| Back Pain | ❑ Yes | ❑ No |
| Frequent Urination | ❑ Yes | ❑ No |
| Groin Mass | ❑ Yes | ❑ No |
| Blood in Urine | ❑ Yes | ❑ No |
| Urinary Incontinence | ❑ Yes | ❑ No |
| Tea/Cola Colored Urine | ❑ Yes | ❑ No |

### REPRODUCTIVE

Menarche Age _____

LMP _____

HRT _____

Self Breast Exams _____

Last Mammo _____

Last PAP Smear _____

| | | |
|---|---|---|
| Breast Discharge | ❑ Yes | ❑ No |
| Breast Lumps | ❑ Yes | ❑ No |
| Breast Pain | ❑ Yes | ❑ No |
| Fibroids | ❑ Yes | ❑ No |
| History of Abnormal PAP Smears | ❑ Yes | ❑ No |
| History of Infertility | ❑ Yes | ❑ No |
| Oral Contraceptive Use | ❑ Yes | ❑ No |
| Ovarian Cyst | ❑ Yes | ❑ No |
| Vaginal Itch | ❑ Yes | ❑ No |
| Vaginal Discharge | ❑ Yes | ❑ No |

### METABOLIC

| | | |
|---|---|---|
| Change in Sleep Pattern | ❑ Yes | ❑ No |
| Cold Intolerence | ❑ Yes | ❑ No |
| Decreased Activity | ❑ Yes | ❑ No |
| Goiter | ❑ Yes | ❑ No |
| Hair Loss | ❑ Yes | ❑ No |
| Heat Intolerence | ❑ Yes | ❑ No |
| Voice Change | ❑ Yes | ❑ No |
| Gestational Diabetes | ❑ Yes | ❑ No |

### NEUROLOGICAL

| | | |
|---|---|---|
| Dizziness | ❑ Yes | ❑ No |
| Weakness | ❑ Yes | ❑ No |
| Trouble Walking | ❑ Yes | ❑ No |
| Light Headedness | ❑ Yes | ❑ No |
| Loss of Consciousness | ❑ Yes | ❑ No |
| Memory Impairment | ❑ Yes | ❑ No |
| Seizures | ❑ Yes | ❑ No |
| Speech Changes | ❑ Yes | ❑ No |
| Tremors | ❑ Yes | ❑ No |
| Vision Changes | ❑ Yes | ❑ No |

### DERMATOLOGIC

| | | |
|---|---|---|
| Contact Allergies | ❑ Yes | ❑ No |
| Frequent Skin Infections | ❑ Yes | ❑ No |
| Hair Loss | ❑ Yes | ❑ No |
| Nail Changes | ❑ Yes | ❑ No |
| Rash | ❑ Yes | ❑ No |
| Change in Mole | ❑ Yes | ❑ No |
| Skin Lesions | ❑ Yes | ❑ No |

### MUSCULOSKELETAL

| | | |
|---|---|---|
| Back Pain | ❑ Yes | ❑ No |
| Bone/Joint Symptoms | ❑ Yes | ❑ No |
| Muscle Weakness | ❑ Yes | ❑ No |
| Neck Stiffness | ❑ Yes | ❑ No |

### HEMATOLOGIC

| | | |
|---|---|---|
| Easy Bleeding | ❑ Yes | ❑ No |
| Easy Bruising | ❑ Yes | ❑ No |
| Swollen Lymph Nodes | ❑ Yes | ❑ No |

### IMMUNOLOGICAL

| | | |
|---|---|---|
| Hay Fever | ❑ Yes | ❑ No |
| Hives | ❑ Yes | ❑ No |
| Bee Sting Allergies | ❑ Yes | ❑ No |
| Environmental Allergies | ❑ Yes | ❑ No |
| Food Allergies | ❑ Yes | ❑ No |

**PAST SURGICAL HISTORY (Please include dates):** _____

_____

_____

_____

## PAST ILLNESES OF YOURSELF AND FAMILY

| You | Your Family | | You | Your Family | | You | Your Family | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Alcoholism | ❑ | ❑ | High Blood Pressure | ❑ | ❑ | Stroke |
| ❑ | ❑ | Anemia | ❑ | ❑ | Kidney Disease | ❑ | ❑ | Suicide Attempt |
| ❑ | ❑ | Asthma | ❑ | ❑ | Liver Disease | ❑ | ❑ | Thyroid Disease |
| ❑ | ❑ | Cancer/Tumor | ❑ | ❑ | Hepatitis | ❑ | ❑ | Tuberculosis, TB |
| ❑ | ❑ | Diabetes | ❑ | ❑ | Lung Disease | ❑ | ❑ | Ulcer in GI Tract |
| ❑ | ❑ | Drug Abuse | ❑ | ❑ | Mental Illness | ❑ | ❑ | Venereal Disease |
| ❑ | ❑ | Depression | ❑ | ❑ | Osteoarthritis | ❑ | ❑ | High Cholesterol |
| ❑ | ❑ | Epilepsy/Seizures | ❑ | ❑ | Osteoporosis | ❑ | ❑ | HIV/Immune DX |
| ❑ | ❑ | Glaucoma | ❑ | ❑ | Phlebitis | ❑ | ❑ | Other_____ |
| ❑ | ❑ | Heart Disease | ❑ | ❑ | Rheumatic Arthritis | | | |

## SOCIAL HISTORY

Smoker ❑ Yes ❑ No Type:_____ _____/Day _____Years Ever tried to quit? ❑ Yes ❑ No

Alcohol Use ❑ Yes ❑ No Type:_____ Amount daily:_____

Caffeine Use ❑ Yes ❑ No Type:_____ Amount daily:_____

| | WHEN | WHERE |
|---|---|---|
| Last Mammogram | _____ | _____ |
| Last Colonoscopy | _____ | _____ |
| Last CTScan | _____ | _____ |