

NAME: _____ DATE: _____

EMAIL: _____

D.O.B.: _____ AGE: _____

NAME AND PHONE NUMBER OF PRIMARY MEDICAL DOCTOR:

MAY WE RELEASE YOUR OFFICE NOTES TO THIS DOCTOR?

YES: _____ NO: _____ PLEASE SIGN: _____

WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE?
(Name and number, or source of referral)

MICHAEL J. MAYNARD, MD
PATIENT HISTORY & PHYSICAL FORM

PLEASE COMPLETE THIS HISTORY FORM AND RETURN IT TO THE NURSE WHEN YOU ARE PUT IN AN EXAMINATION ROOM. DO NOT LEAVE ANY QUESTIONS BLANK, AS YOUR ANSWERS ARE NEEDED IN ORDER TO EVALUATE AND TREAT YOU. IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK.

COMPLAINT: _____

YOUR HEIGHT: _____ YOUR WEIGHT: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?
PLEASE ANSWER YES OR NO AND DO NOT LEAVE ANY LINES BLANK.

CHEST PAIN	_____ YES	_____ NO
SHORTNESS OF BREATH	_____ YES	_____ NO
HEART ATTACK	_____ YES	_____ NO
HIGH CHOLESTEROL	_____ YES	_____ NO
HIGH BLOOD PRESSURE	_____ YES	_____ NO
DIABETES	_____ YES	_____ NO
GOUT	_____ YES	_____ NO
PERIPHERAL VASCULAR DISEASE	_____ YES	_____ NO

STOMACH ULCER	_____ YES	_____ NO
BLOOD CLOTS	_____ YES	_____ NO
TREATED WITH BLOOD THINNER	_____ YES	_____ NO
ASTHMA	_____ YES	_____ NO
CANCER	_____ YES	_____ NO
DEPRESSION	_____ YES	_____ NO
RHEUMATOID DISEASE	_____ YES	_____ NO

LIST ANY OTHER MEDICAL CONDITIONS:

NAME: _____ DATE: _____

DO YOU HAVE A FAMILY HISTORY OF HEART DISEASE, IF YES PLEASE EXPLAIN?

DO YOU HAVE A FAMILY HISTORY OF ORTHOPEDIC OR ARTHRITIC CONDITIONS? PLEASE LIST ALL SURGERIES YOU HAVE HAD. MAKE SURE TO INCLUDE DATES WHENEVER POSSIBLE:

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? IF SO, PLEASE LIST THE NAMES OF THE MEDICATIONS.

PLEASE LIST ALL MEDICATIONS YOU TAKE ON A REGULAR BASIS. MAKE SURE TO INCLUDE DOSAGES WHENEVER POSSIBLE.

DO YOU SMOKE? IF SO, PLEASE STATE HOW MUCH.

DO YOU DRINK ALCOHOL? HOW OFTEN AND HOW MUCH?

WHAT CURRENT LEISURE ACTIVITIES DO YOU PARTICIPATE IN?
PLEASE CHECK ALL THAT APPLY.

GOLF___ TENNIS___ SWIMMING___ BIKING___ HIKING___

EXERCISE WALKING___ BOATING___ SNOW SKIING___

GARDENING___ BOWLING___ OTHER_____