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HISTORY AND PHYSICAL

Date _____

Your Name _____ Age _____

Chief Complaint _____

Why are you seeing the doctor today? _____

Present Illness

Who referred you? _____

Who is your current medical doctor? _____

When did this first start? _____

How did this start? Accident Gradual Infection

What has your previous treatment been? _____

Past Medical History

Current Medications _____

Previous Surgery _____

Allergies _____

Are you diabetic? _____ If yes, your average sugar? _____

Cardiologist _____

Neurologist _____

Pain Management Dr. _____

Rheumatologist _____

Pulmonary Dr. _____

Other Orthopaedic Dr. _____

Family History

| Member | Alive | Deceased | Age | Health Issues |
|----------------|-------|----------|-----|---------------|
| Father | | | | |
| Mother | | | | |
| Sister/Brother | | | | |
| Sister/Brother | | | | |
| Other | | | | |

Social History

Where do you live? Home With family In facility outside of home

Do you smoke? _____ How Much? _____

When did you quit? _____

Do you use alcohol? _____ How Much? _____

When did you quit? _____

What is your employment? _____

What is your usual exercise level? _____

Review of Systems (circle and describe any problems)

| | |
|----------------------|--|
| Eyes | |
| Ears, nose, & throat | |
| Lungs & breathing | |
| Heart problems | |
| Liver problems | |
| Digestion | |
| Kidney problems | |
| Bladder problems | |
| High blood pressure | |
| Balance problems | |
| Blackout/fainting | |
| Seizures | |
| Cancer | |
| Skin problems | |
| Arthritis | |
| | |

*****FOR OFFICE USE ONLY*****

Date _____ Ht. _____ Wt. _____ B.P. _____ / _____ Pulse _____

