

WESTSIDE ENDOSCOPY OBS

BARRY W. JAFFIN, M.D

ANTHONY WEISS, M.D.

NEW CONSULT
NAME _____

DOB _____

DATE _____

HISTORY - COMPLETED BY PATIENT, STAFF OR PROVIDER

1. Reason for your visit today _____

<p>2. Please indicate if you are having any current problems signs or symptoms in any of the following areas</p> <table border="0"> <tr> <td><input type="checkbox"/> General wellness</td> <td><input type="checkbox"/> Neurological</td> </tr> <tr> <td><input type="checkbox"/> Eyes</td> <td><input type="checkbox"/> Allergies</td> </tr> <tr> <td><input type="checkbox"/> Skin</td> <td><input type="checkbox"/> Reproductive/Urinary</td> </tr> <tr> <td><input type="checkbox"/> Ears, Nose, Throat</td> <td><input type="checkbox"/> Thyroid/Endocrine</td> </tr> <tr> <td><input type="checkbox"/> Stomach/Digestion</td> <td><input type="checkbox"/> Psychiatric</td> </tr> <tr> <td><input type="checkbox"/> Lungs/Breathing</td> <td><input type="checkbox"/> Blood/Lymph</td> </tr> <tr> <td><input type="checkbox"/> Heart/Circulation</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td><input type="checkbox"/> Muscles/Joints/Bones</td> <td></td> </tr> </table>	<input type="checkbox"/> General wellness	<input type="checkbox"/> Neurological	<input type="checkbox"/> Eyes	<input type="checkbox"/> Allergies	<input type="checkbox"/> Skin	<input type="checkbox"/> Reproductive/Urinary	<input type="checkbox"/> Ears, Nose, Throat	<input type="checkbox"/> Thyroid/Endocrine	<input type="checkbox"/> Stomach/Digestion	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Lungs/Breathing	<input type="checkbox"/> Blood/Lymph	<input type="checkbox"/> Heart/Circulation	<input type="checkbox"/> Other	<input type="checkbox"/> Muscles/Joints/Bones		<p>Physicians comments</p> <p><input type="checkbox"/> All other systems negative ROS: 1 prob. Pertinent, 2-9</p>
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3. List any Past Medical Problems:

4. Please list the types and dates of any operations. (use the back of this page if you need more space)

5. What is your Social History?

Marital Status: Single , Divorced , Married , Widow/Widower ,

Who lives with you? _____ Current Occupation _____

Do you smoke? _____ How many packs a day? _____ For how many years? _____

Do you drink alcohol? _____ How many drinks per day? _____ Per week? _____ Per month? _____

FAMILY ILLNESSES (NOT YOURSELF):

Which relatives?

History of high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
History of diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
History of cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
History of Heart Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
History of Strokes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

____ I have reviewed the History as documented above and personally noted the Chief Complaint and HPI

Signature of provider (attending) _____ date _____

