

William Purtil M.D.

Name: _____ **Age:** _____ **Date:** _____

Primary M.D.: _____ **Cardiologist:** _____

Other M.D.: _____ **Podiatrist:** _____

Chief Complaint (in brief): _____

Past Medical History:

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> COPD or Emphysema |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Home Oxygen |
| <input type="checkbox"/> Diabetes (Insulin Dependent) | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Diabetes (Non-insulin Dependent) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Smoking: Current/Previous | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> _____ packs/day _____ years | <input type="checkbox"/> Peptic Ulcer or GERD |
| <input type="checkbox"/> When did you quit _____ years ago | |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hepatitis (Type): _____ |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Coronary Angioplasty or Stent | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arrhythmia/ Atrial Fibrillation | <input type="checkbox"/> Dialysis: Hemodialysis/Peritoneal |
| <input type="checkbox"/> Congestive Heart Failure (CHF) | <input type="checkbox"/> Difficulty Urinating or BPH |
| <input type="checkbox"/> Stroke: Major/Minor | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Cancer (Type): _____ |
| <input type="checkbox"/> Mini-stroke or TIA | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Clotting Tendency | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Blood Clot or DVT | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> Leg Wound or Ulcer | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Gangrene | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Peripheral Arterial Disease | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

William Purtil M.D.

Past Surgical History:

Medications:

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<hr/>	<hr/>
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Allergies: (Medications, IV Dye, etc.,)

Medication

Reaction

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<hr/>	<hr/>
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Social History:

Occupation: _____

Marital Status: _____

Live Alone: Yes/No

Drugs of Abuse: _____

Alcohol per week: _____

Smoking: _____

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Family History:

- High Blood Pressure
- High Cholesterol
- Diabetes
- Heart Disease
- Cancer
- Stroke
- Bleeding
- Clotting or DVT
- Varicose Veins

Review of Systems: (Currently Have or Recently Had These Symptoms)

Constitutional

- Fever/Chills
- Unexplained Weight Loss/Gain
- Unexplainable Fatigue

Cardiovascular

- Chest Pain/Tightness
- Shortness of Breath
- Palpitations
- Fainting Spells
- Ankle Swelling
- Pain in Legs with Walking

Respiratory

- Chronic Cough
- Frequent Phlegm or Sputum
- Wheeze
- Cough up Blood

Neurological

- Frequent Headache
- Frequent Dizziness
- Double Vision
- Ringing in Ears
- Nose Bleeds
- Seizures
- Tremors
- Memory Loss

Hematologic/Lymphatic

- Bleeding Tendency
- Bruise Easily
- Leg Swelling
- Have Enlarged Nodes

Other Complaints

- _____
- _____
- _____

Gastro-Intestinal

- Recent Vomiting
- Recent Diarrhea
- Recent Constipation
- Blood in Stool
- Abdominal Pain

Genito-Urinary

- Difficulty Urinating
- Urinate at night more than twice
- Blood in urine
- Frequent urinary infections
- Incontinence
- Irregular Menses
- Post-menopausal Bleeding
- Miscarriage: How Many _____

Musculoskeletal

- Frequent Muscle Pain
- Frequent Joint Pain
- Muscle Weakness
- Cold Extremities

Skin

- Rash
- Frequent Itch
- Cellulitis

Psychiatric

- Frequently Feel Anxious
- Feel Depressed
- Thought About/Attempted Suicide
- Have Hallucinations or Hear Voices

- _____
- _____

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Examination:

Vitals: **Pulse:** ___ **BP:** ___ **Respiratory Rate:** ___ **Temp:** ___

Height: _____ **Weight:** _____

CNS: _____

HEENT: _____

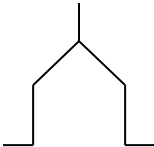
Carotids: _____

Cardiac: _____

Respiratory: _____

Abdomen: _____

Extremities:



Tests:

Impression/Plan:

_____ **William Purtil M.D.**