

**NEW PATIENT HEALTH EVALUATION**

**Patient Name:** \_\_\_\_\_ **Chart Number:** \_\_\_\_\_

**Date of Visit:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **Attending Physician:** PVS

**Chief Complaint:** \_\_\_\_\_

**HPI:** What: \_\_\_\_\_

How: \_\_\_\_\_

When: \_\_\_\_\_

Where: \_\_\_\_\_

**Past Medical History:** Sleep apnea \_\_\_\_\_ no / yes  
Cardiovascular: Negative / CABG \_\_\_\_ / Stent \_\_\_\_ /  
Endocrine: Negative / DMI / II \_\_\_\_ BLOOD SUGAR  
Pulmonary: Negative / COPD / ASTHMA /

**Patient candidate for** SJH / POSA  
**Time App:**  
**Anesthesia** GETA / MAC / BLOCK

**Past Surgical History** \_\_\_\_\_

**Social History:** Occupation: \_\_\_\_\_ Lives with: \_\_\_\_\_

Marital status: S / M / D / Children: \_\_\_\_ B / \_\_\_\_ G Smoking: No / Yes \_\_\_\_\_ Alcohol: No / Yes \_\_\_\_\_

**Family History:** Negative / Grandparents \_\_\_\_\_

Parents \_\_\_\_\_

Brothers \_\_\_\_\_

Sisters \_\_\_\_\_

**Current Medications:** (Name & Dosage)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** NKDA / Penicillin / Sulfa / Codeine / ASA / other

List reactions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Rash \_\_\_\_\_  
Hives \_\_\_\_\_  
N/V \_\_\_\_\_

**Review of Systems:** General:

**Skin:** Negative / or rashes or itching.

**Head / Ears / Eyes:** Negative / or ringing deafness, nose bleeds, sores in the mouth or difficulty.

**Cardiac:** Negative / or chest pain, heart pounding or palpitations.

**Pulmonary:** Negative / or shortness of breath or coughing.

**Gastrointestinal:** Negative / or nausea, diarrhea, blood in stools or black, tarry stools.

**Urologic:** Negative / or burning or frequency with urination / or

**Musculoskeletal:** Negative / or joint pain, joint stiffness or joint swelling / or

**Neurological:** Negative / or weakness, numbness or dizziness / or

**Endocrine:** Negative / or diabetes or thyroid problems / or

Others \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**General Exam:** Vital signs: B/P \_\_\_\_\_ Pulse \_\_\_\_\_ Respiratory Rate \_\_\_\_\_ Temperature \_\_\_\_\_  
O2 Saturation: \_\_\_\_\_ Blood Sugar \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

**Office X-Rays:** \_\_\_\_\_ views were taken today.

**Lab Data:** \_\_\_\_\_

**Diagnosis:**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Followup Plan:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Medicine Prescribed:** \_\_\_\_\_

Further studies ordered: \_\_\_\_\_

Consult with: \_\_\_\_\_

Weightbearing status: Right / Left / Bilateral / \_\_\_\_\_

Off work / school: \_\_\_\_\_

Return: \_\_\_\_\_ days / weeks / months

Reason: H&P date \_\_\_\_\_ / Surgery date \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reviewed by: PVS    DET    JAK

**Evaluation Type:** X-ray Report shows

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_