Kristina O'Shaughnessy, MD, PLC

History and Physical Form

Name:						**Date:**	
Height:		**Weight:**		**DOB:**		**Age:**	
Reason for Consultation:							
Are you experiencing pain? YES NO				**If so, where? How severe on scale 0-10 (10 = worst pain, 0 = no pain at all)**			

ALL TREATING PHYSICIANS	**LOCATION**	**PHONE NUMBER**
Primary Care:		

PAST MEDICAL HISTORY			
Dates	**Diagnoses**	**Dates**	**Diagnoses**

PAST SURGICAL HISTORY			
Dates	**Surgeries/Procedures**	**Dates**	**Surgeries/Procedures**

FAMILY HISTORY								
Cancers: (Immediate and 2nd generation)								
Heart Disease:	**YES**	**NO**	**WHO:**	**Malignant Hyperthermia:**	**YES**	**NO**	**WHO:**	
Stroke:	**YES**	**NO**	**WHO:**	**Blood/Bleeding Disorders:**	**YES**	**NO**	**WHO:**	
Cholesterol:	**YES**	**NO**	**WHO:**	**Other:**	**YES**	**NO**	**WHO:**	
Diabetes:	**YES**	**NO**	**WHO:**	**Other:**	**YES**	**NO**	**WHO:**	

SOCIAL HISTORY							
Marital Status:		**Number of Children**		**Ages:**			
Do You Drink Alcohol?		**How Often?**	_____ Drinks/day	**For How Many Years?**			
Do You Smoke, Vape, or Use Nicotine Products?		**How Often?**	_____ Packs/day	**For How Many Years?**			
Do You Use Recreational Drugs? If So, Type?							

CURRENT MEDICATIONS AND SUPPLEMENTS		
ALLERGIES		
ANY WEIGHT GAIN OR LOSS IN LAST YEAR?		**IF SO, HOW MUCH?**
ANY PREVIOUS OR CURRENT USE OF WEIGHT LOSS MEDICATION OR INJECTIONS?		

ANY ISSUES WITH ANESTHESIA?	

REVIEW OF SYSTEMS (PLEASE CIRCLE ALL THAT APPLY)					
General/Constitutional					
Chills	Fever	Sleep Disturbance	Weight Gain	Weight Loss	
Ophthalmologic					
Vision Changes	Double Vision	Blurry Vision	Eye Pain	Other Eye Problems	
Ears, Nose, and Throat					
Headaches or Migraines	Ear Pain	Nosebleeds	Sinus Pain	Sore Throat	
Endocrine					
Fatigue	Cold Intolerance/ Heat Intolerance	Diabetes	Excessive Sweating	Excessive Thirst	Thyroid Problems
Respiratory					
Sleep Apnea	Difficulty Breathing	Asthma	Cough	Shortness of Breath at Rest	
Cardiovascular					
Heart Stent or Defibrillator	Blood Thinners	Chest Pain	High Blood Pressure	Palpitations	
Gastrointestinal					
Blood in Stool	Constipation	Diarrhea	Difficulty Swallowing	Heartburn	Nausea or Vomiting
Hematology					
Blood Clotting Disorders	Easy Bleeding	Lymphedema	Easy Bruising	Swollen Glands	History of DVT or PE
Women's Health					
Breast Pain	Vaginal Bleeding Between Periods	History of Miscarriages			
Genitourinary					
Burning with Urination	Incontinence	Urinary Urgency	Difficulty Urinating	Frequent Urination	Kidney Stents or Problems
Musculoskeletal					
Neck Pain or Shoulder Pain	Joint Pain, Swelling, Stiffness	Leg Pain	Arm Pain	Numbness or Tingling	Arthritis/Arthralgia
Skin					
Prolonged Lesions/Lumps	Skin Problems or History of MRSA	Blistering of Skin	Itching	Rash	Skin Cancer
Neurologic					
Dizziness	Fainting	Seizures or Epilepsy	Tremor	Weakness	
Psychiatric					
Mood Changes	Body Image Concerns	Anxiety	Depression	Suicidal Thoughts	

The above information is accurate and complete to the best of my knowledge

Signature: _____ Date: _____