

# H. RUSSELL WRIGHT, JR., M.D., P.A.

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

CHIEF COMPLAINT: \_\_\_\_\_

HISTORY OF PRESENT ILLNESS: \_\_\_\_\_

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

<b>Do you have a Living Will?</b>	<b>YES</b>	<b>NO</b>	<b>Do you have a Medical Power of Attorney?</b>	<b>YES</b>	<b>NO</b>
HOSPITAL	Year	Illness/Operation	Year	Illness/Operation	
ADMITS & SURGERIES:	_____				

Current Medications: _____	Allergies: _____	<b>VITAL SIGNS</b>
_____	_____	WT. _____
_____	_____	B/P: _____
_____	_____	P: _____
_____	_____	R: _____
_____	_____	Temp: _____

**MEDICAL HX.** - + for symptoms or diseases you have experienced and P for current problem

<input type="checkbox"/> Decreased hearing	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Muscle weakness	MALES - Prostate <input type="checkbox"/> PSA test
<input type="checkbox"/> Ringing in Ear	<input type="checkbox"/> Persistent nausea/Vomiting	<input type="checkbox"/> Abdominal pain-chronic	<input type="checkbox"/> Numbness/Tingling sensation	FEMALES: Menstrual Flow -
<input type="checkbox"/> Ear Infections-frequent	<input type="checkbox"/> Gall bladder problems	<input type="checkbox"/> Jaundice/Hepatitis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain/cramps
<input type="checkbox"/> Dizzy spells <input type="checkbox"/> Fainting spells	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Arthritis/Rheumatism	Days of Flow _____ Lgth of cycle _____
<input type="checkbox"/> Failing vision <input type="checkbox"/> Eye Pain	<input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's/Colitis	<input type="checkbox"/> Bloody or tarry stools	<input type="checkbox"/> Back pain-recurrent	1st day of last period _____
<input type="checkbox"/> Double or blurred vision	<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia	<input type="checkbox"/> Urine infections-frequent	<input type="checkbox"/> Bone fracture/Joint injury	<input type="checkbox"/> Pain/bleeding after sex
<input type="checkbox"/> Eye infections-frequent	<input type="checkbox"/> Urine in urine <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Urination _____ overnight >twice	<input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis	# of: Pregnancies <input type="checkbox"/> Abortions _____
<input type="checkbox"/> Nose bleeds-recurrent	<input type="checkbox"/> Urination _____ painful _____ loss of control	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Foot pain <input type="checkbox"/> Cold numb feet	Miscarriages <input type="checkbox"/> Live Births _____
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> decrease in force/flow	<input type="checkbox"/> Moodiness-excessive	<input type="checkbox"/> Rashes <input type="checkbox"/> Hives	Birth Control Method _____
<input type="checkbox"/> Sore throats-frequent	<input type="checkbox"/> Venereal disease	<input type="checkbox"/> Mental illness <input type="checkbox"/> Phobias	<input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema	_____ Flushing/Menopause
<input type="checkbox"/> Hay fever/Allergies	<input type="checkbox"/> Urethral discharge	<input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Difficulty sleeping	Date of last PAP test _____
<input type="checkbox"/> Hoarseness-prolonged	<input type="checkbox"/> Fatigue-chronic	<input type="checkbox"/> Chicken pox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps	<input type="checkbox"/> Depression <input type="checkbox"/> Nervousness	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> Pneumonia/Pleurisy	<input type="checkbox"/> Weight loss-recent	<input type="checkbox"/> Measles <input type="checkbox"/> German Measles	<input type="checkbox"/> Memory loss	Date of last Mammogram _____
<input type="checkbox"/> Bronchitis/Chronic cough	<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes	<input type="checkbox"/> Moodiness-excessive	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> Asthma/Wheezing	<input type="checkbox"/> Cancer	<input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily	<input type="checkbox"/> Mental illness <input type="checkbox"/> Phobias	
<input type="checkbox"/> Shortness of breath/ _____ on exertion <input type="checkbox"/> lying flat	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Alcohol _____ oz per wk	<input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Smoking _____ cig/day _____ #yrs	<input type="checkbox"/> Chicken pox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps	
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke	<input type="checkbox"/> Year Quit _____	<input type="checkbox"/> Measles <input type="checkbox"/> German Measles	
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Tremors/Hands shaking	<input type="checkbox"/> Coffee/Tea _____ cups/day	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes	
<input type="checkbox"/> Palpitations/Irregular pulse		<input type="checkbox"/> Regular exercise	<input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily	
<input type="checkbox"/> Leg pain-walking			<input type="checkbox"/> Alcohol _____ oz per wk	
<input type="checkbox"/> Varicose veins/Phlebitis			<input type="checkbox"/> Smoking _____ cig/day _____ #yrs	
<input type="checkbox"/> Loss of appetite-recent			<input type="checkbox"/> Year Quit _____	
<input type="checkbox"/> Difficulty swallowing			<input type="checkbox"/> Coffee/Tea _____ cups/day	

**Family History:**

1. Epilepsy	6. Thyroid	11. Osteoporosis	16. High cholesterol
2. Migraine	7. Hayfever	12. Arthritis	17. Alcoholism
3. Mental illness	8. Asthma	13. Heart disease	18. Cancer
4. Glaucoma	9. Anemia	14. Stroke	19.
5. Diabetes	10. Bleeds easily	15. Hypertension	20.

**Social History:** Marital status \_\_\_\_\_ Education \_\_\_\_\_ Occupation \_\_\_\_\_