William Purtill M.D.

Name: ________________________ **Age:** ______ **Date:** _________

Primary M.D.: _________________ **Cardiologist:** _____________________

Other M.D.: _____________________ **Podiatrist:** _______________________

Chief Complaint (in brief)**:** ____

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Past Medical History:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes (Insulin Dependent)
- ☐ Diabetes (Non-insulin Dependent)
- ☐ Smoking: Current/Previous
- ☐ ______packs/day _______ years
- ☐ When did you quit ____ years ago
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Coronary Angioplasty or Stent
- ☐ Arrhythmia/ Atrial Fibrillation
- ☐ Congestive Heart Failure (CHF)
- ☐ Stroke: Major/Minor
- ☐ Migraine Headaches
- ☐ Seizure Disorder
- ☐ Mini-stroke or TIA
- ☐ Bleeding Tendency
- ☐ Clotting Tendency
- ☐ Blood Clot or DVT
- ☐ Pulmonary Embolism
- ☐ Varicose Veins
- ☐ Leg Wound or Ulcer
- ☐ Gangrene
- ☐ Peripheral Arterial Disease
- ☐ _____________________
- ☐ _____________________
- ☐ COPD or Emphysema
- ☐ Home Oxygen
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Pneumonia
- ☐ Peptic Ulcer or GERD
- ☐ Hepatitis (Type): _____________
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Dialysis: Hemodialysis/Peritoneal
- ☐ Difficulty Urinating or BPH
- ☐ Incontinence
- ☐ Thyroid Disease
- ☐ Cancer (Type): _______________
- ☐ Anemia
- ☐ Arthritis
- ☐ Back Problems
- ☐ Gout
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ Anxiety
- ☐ Depression
- ☐ Skin Disease
- ☐ Other conditions not listed above:
- ☐ ____________________________
- ☐ ____________________________

William Purtill M.D.

Past Surgical History:

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____

____

Medications:

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

Allergies: (Medications, IV Dye, etc.,)

Medication	**Reaction**
__________________________________	__________________________________
__________________________________	__________________________________
__________________________________	__________________________________

Social History:

Occupation: ________________________ Marital Status: ____________________

Live Alone: Y / N With: _____________ Drugs of Abuse: ____________________

Alcohol per week: _________________ or Rarely / Never

Smoking: __________________________

William Purtill M.D.

Family History: (State Who Was Affected Beside the Condition)

- ◻ 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

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

Other Complaints
- ◻ ____________________
- ◻ ____________________
- ◻ ____________________
- ◻ ________________________________
- ◻ ________________________________

William Purtill M.D.

Examination:

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

Height: ______ **Weight: ______**

CNS: ____

HEENT: ____

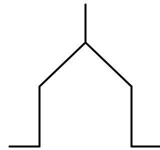
Carotids: ____

Cardiac:____

Respiratory: ____

Abdomen: ____

Extremities:



Tests:

Impression/Plan:

___________________________________ **William Purtill M.D.**