Date: _____

WATSON CLINIC LLP

Quality Healthcare for Every Generation

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THIS IS AN INFORMATIONAL FORM AND IS NOT A PERMANENT PART OF THE MEDICAL RECORD

MEDICAL HISTORY

PLEASE PRINT:

Name: _____ Age: _____ Sex: ❑ M ❑ F Race: _____

Health History of Patient	*Yes*	*No*
Stroke	❑	❑
Heart Trouble	❑	❑
High Blood Pressure	❑	❑
Diabetes	❑	❑
Arthritis	❑	❑
Gout	❑	❑
Seizures	❑	❑
Mental Illness	❑	❑
Kidney Disease/Stones	❑	❑
Cancer	❑	❑
Bleeding Disorders	❑	❑
Alcoholism	❑	❑
Lung Disease	❑	❑
Blood Clots	❑	❑
Anemia	❑	❑
Stomach Ulcers	❑	❑
Liver Disease	❑	❑
Thyroid Problems	❑	❑
Previous Fracture	❑	❑

Explain YES Answers Below:

_____

_____

_____

Prior Surgeries (w/Dates):

_____

_____

_____

_____

_____

_____

Current Medications/Dosage:

_____

_____

_____

_____

_____

_____

Allergies NONE ❑

_____

_____

Social History

Most Recent Occupation: _____

_____

❑ Married ❑ Single
❑ Divorced ❑ Widowed

Number of Living Children_____

Presently living alone?_____

Smoking History: _____packs/day

Alcohol: ❑ Never ❑ Occasional
❑ Past Problem ❑ Frequently Use

Family History	*Yes*	*No*
Stroke	❑	❑
Heart Trouble	❑	❑
High Blood Pressure	❑	❑
Diabetes	❑	❑
Arthritis	❑	❑
Gout	❑	❑
Seizures	❑	❑
Mental Illness	❑	❑
Kidney Disease/Stones	❑	❑
Cancer	❑	❑
Bleeding Disorders	❑	❑
Alcoholism	❑	❑

Explain YES Answers Below:

_____

_____

_____

Parents/Siblings Cause of Death:

_____

_____

_____

Review of Systems	*Yes*	*No*
Reading Glasses	❑	❑
Vision Changes	❑	❑
Hearing Loss	❑	❑
Ear Pain	❑	❑
Hoarseness	❑	❑
Nosebleeds	❑	❑
Difficulty Swallowing	❑	❑
Morning Cough	❑	❑
Short of Breath	❑	❑
Fever/Chills	❑	❑
Heart/Chest Pain	❑	❑
Abnormal Heartbeat	❑	❑
Swollen Ankles	❑	❑
Calf Cramps w/Walking	❑	❑
Poor Appetite	❑	❑
Toothache	❑	❑
Stomach Pain	❑	❑
Gas	❑	❑
Nausea/Vomiting	❑	❑
Diarrhea	❑	❑
Bloody Bowel Movements	❑	❑
Constipation	❑	❑
Hemorrhoids	❑	❑
Frequent Urination	❑	❑
Poor Bowel Control	❑	❑
Poor Bladder Control	❑	❑
Headaches	❑	❑
Blackouts	❑	❑
Seizures	❑	❑
Hot/Cold Spells	❑	❑

	Yes	*No*
Rashes	❑	❑
Recent Weight Change	❑	❑
Insomnia	❑	❑
Depression	❑	❑

WOMEN ONLY	*Yes*	*No*
Irregular Periods	❑	❑
Vaginal Discharge	❑	❑
Frequent Spotting	❑	❑

Athletic Activities:_____

_____

_____

Hand Dominance ❑ Right ❑ Left

PRESENT COMPLAINT:

Chief Complaint: _____

_____

_____

Since when? _____

_____

Was there an injury? _____

_____

_____

Where is your pain?_____

_____

_____

Describe your pain:
❑ Numb ❑ Pressure ❑ Sharp
❑ Dull ❑ Crampy ❑ Throbbing
❑ Locking ❑ Unstable
❑ Constant ❑ Intermittent

What makes symptoms . . .

Worse? _____

_____

Better?_____

_____

_____

Previous Studies (X-ray, MRI, Blood Tests):

_____

_____

Prior Treatment:
❑ Steroid Injection
❑ Oral Medication
❑ Surgery
❑ Physical Therapy
❑ Other (describe):_____

_____

Initials _____

NEW PATIENT EXAM

Name: _____

PHYSICAL EXAM:

VS: WT:_____ HT:_____ PULSE:_____ TEMP:_____

GENERAL: WD/WN NAD

MSE: A & O

INSPECTION: (alignment/symmetry)

CARDIOVASCULAR: (swelling/erythema/warth/pulses)

PALPATION: (tenderness/effusion)

ROM: (pain/crepitus)

STRENGTH/TONE:

STABILITY:

NEURO: (DTRs/sensory)

SPECIAL TEST:

X-RAYS: (Date_____)

IMPRESSION:

PLAN:

☐ DICTATION