WEEKENDS Plus Urgent Care

3189 Hwy 45 N, Suite H • Columbus, MS 39701 • Phone: (662) 570-4507

PHYSICAL EXAMINATION FORM

☐ Initial Exam ☐ Annual

1. PATIENT INFORMATION

Name (Last, First, Middle): _____ **SSN:** _____-_____-_____

Date of Birth: _____/_____/_____ **Marital Status:** ☐S ☐M ☐W ☐D **Religion:** _____

Address: _____ **Telephone:** _____

Next of Kin: _____ **Relationship:** _____ **Telephone:** _____

Family Physician: _____ **Telephone:** _____

2. FAMILY MEDICAL HISTORY & LIFESTYLE

Family Member	Age	State of Health	If Deceased, Cause	Age at Death
Father				
Mother				
Brother(s)				
Sister(s)				

SMOKING HISTORY

Do you smoke? ☐Yes ☐No

If yes, # per day: _____

☐Never smoked

Stopped smoking (date): _____

Has any blood relative (parent, sibling, grandparent) had:

☐Asthma / Hay fever • ☐Cancer • ☐Diabetes • ☐Heart Trouble / Stroke / Clots • ☐High Blood Pressure • ☐Kidney trouble • ☐Thyroid Disease • ☐Tuberculosis

3. PERSONAL MEDICAL HISTORY

Have you ever had or do you currently have any of the following? (Check all that apply)

☐Abnormal Pap Smear	☐Pneumonia	☐Liver Disease	☐Heart Trouble
☐Dysentery	☐Asthma / Hay Fever	☐Scarlet Fever	☐Meningitis
☐High Blood Pressure	☐Epilepsy	☐Cancer / Leukemia	☐Strep Throat
☐Pain in Chest	☐Jaundice	☐Goiter / Thyroid Tx	☐Convulsions
☐Alcohol / Drug Use	☐Rectal Trouble	☐Malaria	☐Hepatitis B
☐Eating Disorder	☐Bleeding Disorders	☐Sinusitis	☐Migraine Headaches
☐Hodgkin's Disease	☐Frequent Headaches	☐Chicken Pox	☐Tuberculosis
☐Pleurisy	☐Kidney Trouble	☐Heart Murmur	☐Diabetes
☐Anemia	☐Rheumatic Fever	☐Measles	
☐Encephalitis	☐Bloody Urine	☐STDs / STI	
☐Infectious Mono	☐Gallbladder Disease	☐Chronic Cough	

4. ADDITIONAL MEDICAL DETAILS & FEMALE HEALTH

Serious illnesses or hospitalizations: _____

Surgeries or injuries (broken bones, etc.): _____

Allergies (drugs, food, plants, other): _____

Current medications: _____

Female Health: Menstrual onset age: ____ **Last period date:** ____/____/____ **Days between:** ____ **Flow days:** ____ **Flow:** ☐Heavy ☐Med ☐Light

Pain with periods: ☐Yes ☐No **Abnormal periods:** ☐Yes ☐No **Pregnancies:** _____ **Contraceptive type:** _____

5. PATIENT ACKNOWLEDGMENT & SIGNATURE

I authorize the health care professional at the above address to: (1) Receive my medical history information from my primary care physician (2) Receive my prescription records from my pharmacies (3) Release my treatment information/records to pertinent healthcare professionals, as medically necessary (4) Release my treatment information to the health insurance company listed in my health records, for billing purposes (5) Release and receive medically relevant information with authorized legal representatives.

Patient / Guardian Signature: _____ **Date:** _____/_____/_____

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PHYSICAL EXAMINATION RECORD (PAGE 2)

1. PATIENT VITALS & CLINICAL HEADER

Patient's Name: _____ **LMP:** _____

Blood Pressure: _____ **Pulse:** _____ **Weight:** _____ **Height:** _____

2. PHYSICAL EXAMINATION FINDINGS

Normal	Abnormal	Check appropriately and describe abnormalities
☐	☐	**Head, Scalp and Face**
☐	☐	**Eyes** — Date of last Exam: _____
☐	☐	**Vision** — With glasses ☐ Without glasses ☐ Right: _____ Left: _____
☐	☐	**Color vision** — _____
☐	☐	**Ears**
☐	☐	**Nose**
☐	☐	**Mouth and throat**
☐	☐	**Teeth** — Last Exam: _____
☐	☐	**Neck**
☐	☐	**Lungs**
☐	☐	**Heart**
☐	☐	**Breasts**
☐	☐	**Abdomen**
☐	☐	**Rectal**
☐	☐	**Hernia**
☐	☐	**Adenopathy**
☐	☐	**Musculo-skeletal**
☐	☐	**Neurological**
☐	☐	**Skin**
☐	☐	**Femoral and pedal pulses**
☐	☐	**PELVIC**
☐	☐	**Ext. Gen and BUS**

3. LABORATORY WORK & VACCINES

Labwork: ☐Pap Smear ☐GC ☐UA ☐CBC ☐Rubella Titer ☐RPR

Other Labwork: _____

Date of last Tetanus (Td) vaccine: _____

4. SUMMARY OF FINDINGS & RECOMMENDATIONS

a. Physical Findings: _____

b. Mental Findings: _____

c. Recommendations for follow up: _____

5. PROVIDER AUTHORIZATION

Signature of Physician or NP: _____ **Date of Exam:** _____/_____/_____