NewYork-Presbyterian
Medical Group Hudson Valley

Patient History & Physical Form

Last Name:	First Name:	MI:	Date of Birth:
Mother/Guardian:	Occupation:	How many brother and sisters?	
Father/Guardian:	Occupation:	Who does the patient live with?	
Primary Care Physician/Pediatrician:	Other doctors involved with your care:		

REVIEW OF SYSTEMS:

Has the patient ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided. Is your family physician aware of any symptoms/illnesses that you have checked below? Yes___ No___

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
Birth History			**Cardiac**			**Neurologic**			**Ear, Nose, & Throat**		
Normal			High blood pressure			Seizures			Loose Teeth		
Premature			Low blood pressure			Weakness			Nosebleeds		
Cesarean			Irregular heartbeat			Migraines			Deafness		
Prematurity			Chest pain			Previous stroke			**Psychosocial**		
Apnea/Bradycardia			**Respiratory**			**Musculoskeletal**			Alcoholism		
Intubation			Asthma			Muscle Disease			Substance Abuse		
BPD			Pneumonia			Arthritis			Depression		
ECMO			Bronchitis			Neck pain			Anxiety disorders		
Gastrointestinal			Chronic Cough			Back pain			**Breast**		
Diarrhea			Hoarseness			Blood Disorders			Lumps		
Constipation			Tracheostomy			Skin			Cancer		
Rectal Bleeding			**Genitourinary**			Rash			**Please list below:**		
Heartburn			Kidney Disease			Bruises			**Any symptoms/diseases**		
Trouble swallowing			Frequent urine infection			**Ophthalmology**			**Not listed above?**		
Nausea			**Endocrine/Metabolic**			Cataracts					
Vomiting			Diabetes			Glaucoma					
Abdominal Pain			Thyroid Disorders			Blindness					

PAST HISTORY:

Please explain any YES answers in detailed description in the box provided.

Have you ever had any surgery or been Hospitalized? Have you ever had any problems with anesthesia?	**No Yes**	**Surgeries:**	**Dates**	**Hospitalizations other than surgery:**	**Dates**
Explain:					
Other:					

Are you currently or have you ever used any Tobacco or alcohol products?	**No Yes**	**Tobacco: How many packs per day: Per week: Per month: How many yrs:** **Alcohol: How many drinks per day: Per week: Per month: How many yrs:**
Are you or have you ever used recreational /illicit drugs?	**No Yes**	**If yes, what kind? For how long?**

Are you currently taking any medications or drugs	**No Yes**	**Medication**	**Dose**	**Times**	**Medication**	**Dose**	**Times**
Birth control pills?	**No Yes**						
Vitamins or Supplements?	**No Yes**						
Do you have any allergies (including environmental, medication, food, and reaction to previous blood transfusion)?	**No Yes**	**List:**					

Family Hx: Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions:

Condition	Relation to patient	Condition	Relation to patient	Condition	Relation to patient
Colon/ Rectal Cancer No Yes		Kidney problems No Yes		Heart Disease No Yes	
Stomach Cancer No Yes		Ulcerative Colitis No Yes		Crohn's Disease No Yes	
Breast Cancer No Yes		Ovarian Cancer No Yes		Bleeding Problems No Yes	

If not Patient, Person Completing Form/Relationship to Patient: _____ Date: _____