R | S | N
RADIOLOGY SPECIALISTS
OF THE NORTHWEST

Patient History and Physical

Date: _____

Patient Name: _____ Date of Birth: _____
Age:_____

Chief Complaint/What brings you to our office?

_____

_____

Current Medications and Dosage:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies to Medications:

_____ _____ _____

Social History:

Use of Tobacco: ____never ____rarely ____sometimes ____daily *For how many years?_____
Use of Alcohol: ____never ____rarely ____sometimes ____daily
Use of Drugs: ____never ____rarely ____sometimes ____daily
**If you have a history of use of any of the above, when did you quit? _____

Medical History (please mark for self and list family member if applicable)

	Self:	Family Member:
Heart Disease	_____	_____
Cancer	_____	_____
Lung Disease	_____	_____
Stroke	_____	_____
High Blood Pressure	_____	_____
Diabetes	_____	_____

Previous Surgeries and Hospitalizations with dates:

_____ _____ _____

_____ _____ _____

Review of Systems (please circle yes or no):

Vascular	
Pain with walking that is relieved with rest	yes/no
Deep Vein Thrombosis	yes/no
Swelling of legs/ankles/feet	yes/no
Aching/pain/muscle cramps in legs	yes/no
Sores or ulcers	yes/no

Cardiovascular/Respiratory	
Heart attacks	yes/no
Coronary artery disease	yes/no
Chest pain/angina	yes/no
Palpitation	yes/no
Congestive heart failure	yes/no
Emphysema/COPD	yes/no
Chronic/frequent cough	yes/no
Shortness of breath	yes/no
Spitting/coughing up blood	yes/no

General

Good general health lately	yes/no
Recent weight change	yes/no
Fevers	yes/no
Fatigue	yes/no
Headaches	yes/no
Infection	yes/no

Eyes

Recent changes in vision	yes/no
Wear glasses/contacts	yes/no
Other: _____	

Endocrine

Excessive thirst or urination	yes/no
Heat or cold intolerance	yes/no
Skin becoming drier	yes/no

Gastrointestinal

Loss of appetite	yes/no
Change in bowel movements	yes/no
Nausea or vomiting	yes/no
Abdominal pain or heartburn	yes/no
Peptic Ulcer	yes/no

Hematology/Lymphatic

Slow to heal after cuts	yes/no
Bleeding or bruising	yes/no
Anemia	yes/no
Past transfusion	yes/no
Enlarged lymph nodes	yes/no

Genitourinary

Frequent urination	yes/no
Burning or painful urination	yes/no
Blood in urine	yes/no
Incontinence	yes/no
Kidney stones	yes/no
Testicular or penile problems (males)	yes/no

Musculoskeletal

Joint pain	yes/no
Joint stiffness/swelling	yes/no
Weakness of muscles/joints	yes/no
Back pain	yes/no
Difficulty walking	yes/no
Cold extremities	yes/no

Ears/Nose/Throat

Hearing loss	yes/no
Earaches or drainage	yes/no
Nosebleeds	yes/no
Frequent sinus infections	yes/no
Frequent sore throats	yes/no
Voice change	yes/no
Swollen glands in neck	yes/no

Integumentary (skin/breast)

Rash or itching	yes/no
Change in skin color	yes/no
Change in hair/nails	yes/no
Breast pain	yes/no
Breast lump	yes/no
Breast discharge	yes/no

Neurological

Light headed or dizzy	yes/no
Convulsions or seizures	yes/no
Numbness or tingling	yes/no
Tremors	yes/no

Psychiatric

Memory loss or confusion	yes/no
Nervousness/anxiety	yes/no

OB/GYN (females only)

Irregular menstruation	yes/no
Unusual vaginal discharge	yes/no
# of pregnancies	_____
# of live births	_____
Date of last pap	_____
Abnormal pap	yes/no

If you answered "yes" to any of the above, please explain:

_____

_____

_____

_____

_____