



University of Michigan  
Health System

University of Michigan, Section of Thoracic Surgery  
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MEDICAL HISTORY QUESTIONNAIRE

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**PERSONAL DATA:**

Please answer the following questions:

Name: \_\_\_\_\_

Today's date: \_\_\_\_\_

Street: \_\_\_\_\_

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

City: \_\_\_\_\_

Birthplace: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security number: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_

UM I.D. number: \_\_\_\_\_

Work Telephone: (\_\_\_\_) \_\_\_\_\_

Insurance source/policy no: \_\_\_\_\_

**REFERRING PHYSICIANS:**

Please check one of the following boxes and provide information on all physicians involved in your care:

- I was referred by one of my physician(s) below
- I referred myself with my physician's knowledge

- I was referred for a second opinion by my physician
- I referred myself without my physician's knowledge

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Street: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Send reports to this physician \_\_\_\_\_

Send reports to this physician

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Street: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Send reports to this physician

Send reports to this physician

**PRESENT ILLNESS:**

Please briefly describe the date of onset of your illness, your symptoms and all tests/treatment you have received:

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**SYMPTOMS:**

I have NEVER experienced any of the symptoms below

Please indicate if you have now or have ever experienced any of the following? (Check all that apply):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> New/changing cough   | <input type="checkbox"/> Difficulty swallowing   | <input type="checkbox"/> Chest pressure/tightness        |
| <input type="checkbox"/> Phlegm/sputum production<br><input type="checkbox"/> clear <input type="checkbox"/> white <input type="checkbox"/> green<br><input type="checkbox"/> brown <input type="checkbox"/> bloody | <input type="checkbox"/> Food "sticking"         | <input type="checkbox"/> Heart attack                    |
| <input type="checkbox"/> Hoarseness/change in voice   | <input type="checkbox"/> Pain with swallowing    | <input type="checkbox"/> Fast/irregular heart beats      |
| <input type="checkbox"/> Wheezing   | <input type="checkbox"/> Regurgitation of food   | <input type="checkbox"/> Palpitations                    |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Nausea/vomiting         | <input type="checkbox"/> Heart murmur                    |
| <input type="checkbox"/> Emphysema  | <input type="checkbox"/> Vomiting blood          | <input type="checkbox"/> Ankle swelling                  |
| <input type="checkbox"/> Pneumonia  | <input type="checkbox"/> Ulcers/stomach trouble  | <input type="checkbox"/> Difficulty breathing at night   |
| <input type="checkbox"/> Tuberculosis   |  | <input type="checkbox"/> Difficulty breathing lying flat |
| <input type="checkbox"/> Pleurisy   | <input type="checkbox"/> Loss of appetite        |  |
| <input type="checkbox"/> Shortness of breath with exertion  | <input type="checkbox"/> Weight loss: _____ lbs. | <input type="checkbox"/> Headaches                       |
| <input type="checkbox"/> Shortness of breath at rest  | <input type="checkbox"/> Weight gain: _____ lbs. | <input type="checkbox"/> Weakness/fatigue                |
| <input type="checkbox"/> Chest pain   | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Pain/aches in joints            |
|   | <input type="checkbox"/> Night sweats            | <input type="checkbox"/> Other: _____                    |

**CURRENT MEDICATIONS:**

Currently, I am NOT taking ANY medications

Please list ALL medications, doses, and frequencies (i.e., twice a day, every 8 hrs, etc.) below:

<u>Name</u>	<u>Dose</u>	<u>How often?</u>	<u>Name</u>	<u>Dose</u>	<u>How often?</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

- I sometimes take over the counter medications containing Aspirin (Anacin, etc).  
 I sometimes take over the counter medications containing Ibuprofen (Advil, Motrin, etc.).

**MEDICATION/FOOD ALLERGIES:**

I have NO known food or drug allergies

Please list ALL allergies and reactions to medications and food:

<u>Medication/Food</u>	<u>Reaction:</u>
_____	_____
_____	_____
_____	_____

**SUBSTANCE USE:**

Please answer the following questions:

**Tobacco:**Do you now, or have you ever smoked cigarettes?  Yes  No

At the most, how many packs of cigarettes did/do you smoke each day? \_\_\_\_\_ packs

At what age did you start smoking? \_\_\_\_\_ years

Are you currently smoking?  Yes  No If no, at what age did you quit? \_\_\_\_\_Do you now, or have you ever smoked cigars, or a pipe?  Yes  NoDo people close to you smoke?  Yes  NoHow soon after you wake up do you start smoking?  Within 30 min.  After 30 minHow interested are you in stopping smoking?  Not at all  A little  somewhat  very interested

If you decided to quit smoking during the next 2 weeks, how confident are you that you would succeed?

 Not at all  A little  somewhat  very confident**Alcohol:**Do you now, or did you ever drink alcohol?  Yes  No

If yes, how much beer do you, or did you drink? \_\_\_\_\_/day

How much wine do you, or did you drink? \_\_\_\_\_/day

How much hard liquor do you, or did you drink? \_\_\_\_\_/day

During the last week, on how many days did you have a drink? \_\_\_\_\_ days

When was the last time you drank an alcoholic beverage? \_\_\_\_\_

Have you ever felt bad or guilty about your drinking?  Yes  NoHave you ever had to have a drink in the morning to steady your nerves?  Yes  NoHave you ever had black-outs or memory loss?  Yes  NoHave you ever had seizures or the "DT's"?  Yes  No**Other:**Do you drink coffee?  Yes  No

If yes, how many cups each day do you drink? \_\_\_\_\_

Have you ever been exposed to asbestos?  Yes  No

If yes, when were you exposed? \_\_\_\_\_

How were you exposed? \_\_\_\_\_

Have you ever used any drugs such as marijuana, cocaine, amphetamines?  Yes  No

If yes, which one(s): \_\_\_\_\_ when was the last time used: \_\_\_\_\_

Have you ever injected drugs (such as heroin, or cocaine), into your veins?  Yes  No

If yes, which one(s): \_\_\_\_\_ when was the last time used: \_\_\_\_\_

**PREVIOUS SURGERY:** I have NEVER had an operation of any kind

Please list ALL operations you have had including: tonsils, appendix, hemorrhoids, hysterectomy, prostate surgery, etc:

<u>DATE</u>	<u>OPERATION</u>	<u>HOSPITAL</u>	<u>SURGEON</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**MEDICAL HISTORY:** I have NEVER experienced any of the symptoms below

Please indicate if you have now or have ever been told that you have any of the following? (Check all that apply):

<input type="checkbox"/> Abnormal EKG	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Abnormal Treadmill test	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Angina/chest discomfort or pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Kidney Problem
<input type="checkbox"/> Heart condition	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

**HOSPITALIZATIONS:** I have NEVER been hospitalized for any reason

Please list all hospitalizations excluding those for uncomplicated child birth:

<u>DATE</u>	<u>ILLNESS</u>	<u>HOSPITAL</u>	<u>PHYSICIAN</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**RADIATION THERAPY:** I have NEVER received radiation therapy of any kind

Please list any prior radiation treatments you have received:

<u>START DATE</u>	<u>STOP DATE</u>	<u>BODY AREA TREATED</u>	<u>HOSPITAL</u>	<u>PHYSICIAN</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**CHEMOTHERAPY:** I have NEVER received chemotherapy of any kind

Please list any chemotherapeutic agents you have received:

<u>START DATE</u>	<u>STOP DATE</u>	<u>AGENTS (IF KNOWN)</u>	<u>HOSPITAL</u>	<u>PHYSICIAN</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**FAMILY HISTORY:** I have no knowledge of any of my living or deceased relatives

Please record the state of health of your close blood relatives, i.e., mother, father, sisters, brothers, aunts, uncles, and grandparents:

<u>RELATIVE</u>	<u>ALIVE? YES/NO</u>	<u>HEALTH PROBLEMS/CAUSE OF DEATH</u>	<u>AGE NOW/AT DEATH</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Grandfather	_____	_____	_____
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Grandmother	_____	_____	_____
Sister/Brother	_____	_____	_____
Sister/Brother	_____	_____	_____
Sister/Brother	_____	_____	_____
Sister/Brother	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

Please indicate if ANY of your blood relatives has/had any of the following conditions (check all which apply):

<u>HEALTH PROBLEM</u>	<u>RELATIVES AFFECTED:</u>	<u>HEALTH PROBLEM:</u>	<u>RELATIVES AFFECTED</u>
<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Anemia/unusual bleeding	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> High Cholesterol	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Kidney problems	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Liver problems	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Obesity	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Strokes	_____
<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Heart trouble	_____	<input type="checkbox"/> Other: _____	_____

**SOCIAL HISTORY:**Please complete the following questions as **COMPLETELY** as possible:Marital Status:  Single  Married  Divorced  WidowedEmployment history:  Currently employed Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Unemployed  Retired (Date): \_\_\_\_\_  Disabled (Date): \_\_\_\_\_

Previous Occupation: \_\_\_\_\_

What level of education have you attained?  Grade school  High School  College  ProfessionalHave you traveled outside the U.S?  No  Yes If yes, Where? \_\_\_\_\_ When? \_\_\_\_\_Have you ever served in the military?  No  Yes If yes, Which branch? \_\_\_\_\_With whom do you live \_\_\_\_\_  I live aloneDo you have difficulty dressing yourself?  No  YesDo you have difficulty carrying a 10 lb. bag or shopping?  No  YesHave you ever fallen at home?  No  Yes If yes, When? \_\_\_\_\_Are you receiving any special help at home?  No  Yes If yes, Who helps you? \_\_\_\_\_Do you follow any special diet?  No  Vegetarian  Kosher  Low fat  Other: \_\_\_\_\_

**GYNECOLOGIC/OBSTETRICAL HISTORY (WOMEN ONLY):**

Please answer the following questions:

**Gynecologic History:**

- At what age did you begin menstruating? \_\_\_\_\_ years
- What is/was the interval between your menstrual periods? \_\_\_\_\_ days/weeks
- What is/was the duration of your menstrual periods? \_\_\_\_\_ days
- What is/was the date that your last period began? \_\_\_\_\_
- Have you stopped having menstrual periods?  No  Yes If so, when? \_\_\_\_\_
- Have you ever had irregular, painful, or heavy menstrual periods?  No  Yes
- Have you ever had bleeding between periods or after menopause?  No  Yes
- Do you have problems with vaginal discharge, pain, or itching?  No  Yes
- Do you have "hot flashes"?  No  Yes
- Have you ever had an abnormal Pap smear?  No  Yes If so, when? \_\_\_\_\_
- When was your most recent Pap smear? \_\_\_\_\_
- When was your most recent Pelvic exam? \_\_\_\_\_
- Have you ever had a Mammogram?  No  Yes If so, date of last exam? \_\_\_\_\_
- How often do you examine your breasts?  Never  Monthly  Other \_\_\_\_\_
- Would you like instruction in breast self-examination?  No  Yes

**Obstetrical History:**

- Have you ever been pregnant?  No  Yes If so, number of times: \_\_\_\_\_
- How many children have you delivered? \_\_\_\_\_
- How many miscarriages have you had? \_\_\_\_\_
- How many abortions have you had? \_\_\_\_\_
- Are you currently using any form of birth control?  No  Yes If so, what type? \_\_\_\_\_
- Have you ever used birth control pills?  No  Yes If so, for how long? \_\_\_\_\_
- Have you had a hysterectomy?  No  Yes If so, when? \_\_\_\_\_
- Have you had your ovaries removed?  No  Yes If so, when? \_\_\_\_\_  
 One ovary  Both ovaries
- Are you now or have you ever been on estrogen(hormone)replacement?  No  Yes

**REVIEW OF SYSTEMS:**

Please indicate if you have now or have ever experienced any of the following symptoms (Check all that apply):

<b><u>SYMPTOM</u></b>	<b><u>WHEN</u></b>		<b><u>SYMPTOM</u></b>	<b><u>WHEN</u></b>	
<b>Infections</b>			Hemorrhoids.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Mumps.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Jaundice.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
German measles.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Hepatitis.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Rheumatic fever.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Cirrhosis.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Rubella.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Liver problems.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Mononucleosis.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Blood transfusions.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Polio.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Gallbladder trouble.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Malaria.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	<b>Urine</b>		
Typhoid fever.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Blood in urine.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Shingles.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Sugar in urine.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Gonorrhea.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Albumin/protein in urine.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Syphilis.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Cloudy urine.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
<b>Skin</b>			Kidney stones.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Rashes.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	<b>Prostate (men only)</b>		
Tumors/unusual moles.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Slow urine stream.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Psoriasis/eczema (circle one)	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Urination at night: (# of times __)	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Hair loss.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	<b>Circulation/Vascular</b>		
<b>Eye</b>			Leg pain with walking.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Eye infection/pink eye.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Poor circulation.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Blurred vision.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Varicose veins.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Cataracts.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	<b>Muscles/Joints</b>		
Glaucoma.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Back/bone pain.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
<b>Ears</b>			Arthritis/rheumatism.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Earache/discharge from ear(s)	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Joint pains/deformity/redness.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Ringling in the ears.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Pain with weather changes.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Spinning sensation/vertigo....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Finger changing colors.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Hearing loss.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Drainage from joints.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
<b>Nose and Mouth</b>			Locking joints.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Sinus trouble.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Muscle aches/stiffness.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Nosebleeds.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Motion limitation.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Bleeding gums.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	<b>Reproduction</b>		
Sore tongue.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Pain with intercourse.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Teeth trouble.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Impotence/loss of libido.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
<b>Lymph</b>			<b>Neurological</b>		
Lumps in groin(s).....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Paralysis.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Neck swelling.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Numbness/tingling of feet/hands.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Lumps in armpits.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Difficulty walking.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
<b>Breasts</b>			Coordination problem/clumsiness.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Lumps/pain in breast(s).....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Speech/memory problems.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Nipple discharge.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Loss of bowel/bladder control.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
<b>Gastrointestinal</b>			Dizziness/fainting spells.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Ulcers/stomach trouble.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Epilepsy/seizures.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Black/tarry bowel movements.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	<b>Psychological</b>		
Bright red bowel movements.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Excessive worry/nervousness.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Unusual constipation.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Depression/nervous disorder.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Unusual diarrhea.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Personality disorder.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Change in stool size.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	<b>Endocrine</b>		
Change in stool color.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Thyroid problems.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Change in stool frequency.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Head/cold intolerance (circle one).....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Indigestion/"gas".....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Unusual thirst/appetite.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Abdominal pain.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Hand/foot swelling/enlargement.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past

**TO BE FILLED OUT BY PHYSICIAN:****PHYSICAL EXAM:**

Wt. \_\_\_ kg Ht. \_\_\_ BP \_\_\_ HR \_\_\_ RR \_\_\_ Temp \_\_\_ °C O<sub>2</sub> Sat (RA/\_\_\_ L/min) \_\_\_ %

- General:** appears  younger  older  equal to the patient's stated age  
 appears in  no  mild  moderate  severe acute distress
- Eyes:** pupils are  equal and reactive  anisocoric  sluggish  Other: \_\_\_\_\_  
 sclera are  anicteric  mildly icteric  moderately icteric  unequally icteris \_\_\_ > \_\_\_
- Ears:** appears  normal  otorrhea  bloody
- Nose:** appears  clear  rhinorrhea  hemorrhage  masses
- Throat:** appears  clear  bleeding gums  poor dentition  pharyngitis  mass: location: \_\_\_\_\_
- Neck:**  supple  lymphadenopathy:  left/ right;  thyromegaly  Other masses: \_\_\_\_\_
- Back:**  CVA tenderness:  left/ right;  spinal tenderness: location: \_\_\_\_\_
- Lungs:**  clear  rales:  left/ right;  rhonchi:  left/ right;  wheezing:  left/ right;  
 dullness to percussion:  left/ right;  vocal fremitus:  left/ right;  egophony
- Heart:** rate/rhythm:  regular/ irregular;  PMI in the 5<sup>th</sup> ICS  murmur: grade:  I/ II/ III/ IV,  
 systolic/ diastolic/ other,  radiation: to ;  ↑S1  ↑S2;  pericardial friction rub
- Abd:** appears:  soft  scaphoid  distended:  mildly/ moderately/ severely;  nontender  
 tender: location \_\_\_\_\_  hepatosplenomegaly  masses: location \_\_\_\_\_
- Vascular:** carotid: Right:  1+ 2+ 3+ 4+ bruit; Left:  1+ 2+ 3+ 4+ bruit  
 radial: Right:  1+ 2+ 3+ 4+ bruit; Left:  1+ 2+ 3+ 4+ bruit  
 femoral: Right:  1+ 2+ 3+ 4+ bruit; Left:  1+ 2+ 3+ 4+ bruit  
 pedal: Right:  1+ 2+ 3+ 4+ bruit; Left:  1+ 2+ 3+ 4+ bruit
- Ext:** clubbing:  1+ 2+ 3+ 4+; cyanosis:  1+ 2+ 3+ 4+;  
 LE edema: Right:  1+ 2+ 3+ 4+; Left:  1+ 2+ 3+ 4+
- Rectal:**  deferred  without masses  mass: locations: \_\_\_\_\_  occult blood
- Prostate:**  deferred  normal size  enlarged without nodule(s)  nodular
- Neuro:** cranial nerves:  intact  deficiencies: \_\_\_\_\_ motor:  intact  deficiencies: \_\_\_\_\_  
 sensory:  intact  deficiencies: \_\_\_\_\_ proprioception:  intact  deficiencies: \_\_\_\_\_
- Psych:** orientation:  X4/ person/ place/ time/ situation; reacts:  appropriate/ inappropriate
- Skin:**  normal  suspicious nevi/lesions: location(s) \_\_\_\_\_  rashes: location(s) \_\_\_\_\_

**IMAGING EXAM:**

**Chest CT:**  lung:  RUL/ RML/ RLL/ LUL/ LLL;  mediastinum  esophagus  chest wall  
 other \_\_\_\_\_;  mass  fluid  infiltrate  adenopathy

PET Scan:

**Bone Scan:**

**Head MRI:**

**PFT:**

**Other:**

**PRIMARY EVALUATION:**

Note dictated by \_\_\_\_\_  Note dictated at \_\_\_\_\_  Dictation number \_\_\_\_\_

**ASSESSMENT:**