**Dr. Joseph Jacobs H&P Encounter Form**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **List Medical** **History List Any Surgeries**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  |  | **Yes** | **No** |
| **Arthritis** |  |  |  | **Adenoidectomy** |  |  |
| **Asthma** |  |  |  | **Appendectomy** |  |  |
| **Cancer** |  |  |  | **Colonoscopy** |  |  |
| **Diabetes** |  |  |  | **Hysterectomy** |  |  |
| **Hypertension** |  |  |  | **Thyroidectomy** |  |  |
| **High Cholesterol** |  |  |  | **Tonsillectomy** |  |  |
| **Hyperthyroidism/Hypothyroidism** |  |  |  | **C-Section** |  |  |
| **Depression/ Anxiety** |  |  |  | **Sinus** |  |  |
| **Acid Reflux** |  |  |  | **Deviated Septum**  |  |  |
| **Snoring or Sleep Apnea****Do you USE a C-PAP Machine** |  |  |  | **Cardiac** |  |  |
| **Vertigo** |  |  |  | **Hernia Repair** |  |  |
| **Headaches** |  |  |  | **Other** |  |  |
| **Other** |  |  |  |  |  |  |

**Family History (**hereditary conditions**):**

**Mother Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Father Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tobacco Use: Yes No Former Light Smoker Alcohol Use: Yes No**

**Drug Use: Yes No Marijuana: Yes No Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies/contraindications to medications:** None Latex Codeine Penicillin Aspirin Other\_\_\_\_\_\_\_\_\_

**Reaction:** Rash Hives Nausea Anaphylaxis Palpitations Dizziness Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications: Name: Dose: Frequency:**

|  |  |  |
| --- | --- | --- |
| **1.** |  |  |
| **2.** |  |  |
| **3.** |  |  |
| **4.** |  |  |
| **5.** |  |  |
| **6.** |  |  |
| **7.** |  |  |
| **8.** |  |  |
| **9.** |  |  |

**Below Vitals to be completed by Medical Assistant:**

**HT: \_\_\_\_\_\_\_\_\_\_ WT:** \_\_\_\_\_\_\_\_\_ **BMI:\_\_\_\_\_\_\_\_\_ BP:\_\_\_\_\_\_\_\_\_\_ P:\_\_\_\_\_\_\_\_\_\_**