Please complete and bring to appointment

Sewit Amde, MD
1 Memorial Square, Suite 2000
Greenfield, IN 46140
317-325-2699

History And Physical Examination

Date of visit:___________

Name: ________________________ Date of Birth:___________ Age:_____

Referred By:______________________Please explain briefly the reason for your visit and the duration of any symptoms:

____
____
____

Please list any previous treatments and results:____________________________
____

Hand Patients – are you:__ Right Handed __ Left Handed

Past Medical History: (Please check any that apply to you):

Details:____

Immunizations up to date, including tetanus? ___ Yes ___ No

Are you able to walk up 2 flights of stairs without getting short of breath?: ___ Yes ___ No

Have you ever had a blood clot anywhere in your body?
___ Yes ___ No

Do you have heart stents? ___ Yes ___ No

Other vascular stents? ___ Yes ___ No

Date Of Last Physical Exam: ____________ Performed by: ___

Allergies:

Drug Reaction

____

Doctor's Notes

	R	L
Tin		
Phal		
2pt		
APB		
FPL		
TA		

	R	L
SN → N		
N → IMF		
BW		
Est		
c/w		

Medications:
Name Dose Times Per Day

Past Surgical History:
Date Procedure Anesthesia Complications

Family Medical History:
Father:____
Mother:____
Siblings:____
Grandparents:____

Social History:
___Caffeine (Amount per day ____________________)
___Alcohol (Amount per day ____________________)
___Tobacco (Amount per day ________________x____years)
___Drugs (type ____________________)
___Single ___Married ___Divorced ___Widowed
Occupation:____
Amount of exercise per week:_______________________________________

Patient Signature:____
Date:____________________