HISTORY & PHYSICAL

DATE:

NAME:	☐ M ☐ F	MARITAL STAUS: ☐ S ☐ M ☐ W ☐D ☐SEP	DATE OF BIRTH:
ADDRESS:		PHONE (H):( ) (O):( )	
OCCUPATION/ EMPLOYER:		INSURANCE:	

FAMILY HISTORY *IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING –PLEASE CHECK (√) AND INDICATE WHICH RELATIVE*

1) ☐ Epilepsy	6) ☐ Thyroid Disease	11) ☐ Osteoporosis	16) ☐ Lipid disorder	
2) ☐ Migraine	7) ☐ Hay fever	12) ☐ Arthritis	17) ☐ Alcoholism	
3) ☐ Mental illness	8) ☐ Asthma	13) ☐ Heart disease	18) ☐ Hepatitis	
4) ☐ Glaucoma	9) ☐ Anemia	14) ☐ Stroke	19) ☐ Cancer	
5) ☐ Diabetes	10) ☐ Bleeds easily	15) ☐ Hypertension	20) ☐	

HOSPITAL ADMISSIONS *not including pregnancies*	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING

MEDICATION	MG	FREQ.	MEDICATION	MG	FREQ.	MEDICATION	MG	FREQ.	MEDICATION ALLERGIES	VACCINE YEAR OF LAST	TEST / EXAM YEAR OF LAST
										Tetanus / Td:	Stool for blood:
										Influenza (flu):	Colonoscopy:
										Pneumonia:	Cholesterol:
										Hepatitis:	Eye:
										TB skin test:	Dental:

MEDICAL HISTORY *CHECK (√) IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING.*

☐ Hearing prob. ☐ Ringing in ear
☐ Dizzy spells ☐ Fainting spells
☐ Vision prob. ☐ Eye pain
☐ Nose bleeds – recurrent
☐ Sinus trouble
☐ Sore throats – frequent
☐ Hoarseness – prolonged
☐ Hayfever / Allergies
☐ Pneumonia / Pleurisy
☐ Bronchitis / Chronic cough
☐ Asthma / Wheezing
☐ Shortness of breath:
☐ on exertion ☐ lying flat
☐ Chest pain
☐ High blood pressure
☐ Heart murmur ☐ Swollen ankles
☐ Irregular pulse ☐ Palpitations
☐ Leg pain
☐ Difficulty swallowing
☐ Varicose veins / Phlebitis
☐ Appetite
☐ loss ☐ gain

☐ Heartburn ☐ Peptic ulcer
☐ Nausea/Vomiting ☐ Gallbladder dis
☐ Abdominal pain – chronic
☐ Jaundice / Hepatitis
☐ Diarrhea ☐ Constipation
☐ Diverticulosis ☐ Chron's/Colitis
☐ Bloody or tarry stools
☐ Hemorrhoids ☐ Hernia
Urination – Overactive bladder:
☐ Overnight > than twice
☐ More than 8 time / 24 hrs.
☐ Urgency to urinate ☐ with leakage
☐ Decrease in force/flow ☐ Painful
☐ Blood in urine ☐ Kidney stones
☐ Urine infections ☐ Prostate prob
☐ Bed wetting
☐ Weight-loss ☐ gain
☐ Anemia ☐ Bruise easily
☐ Cancer ☐ Fatigue / loss of energy
☐ Diabetes ☐ Thyroid disease

☐ Arthritis / Rheumatism ☐ Back pain
☐ Bone fracture / joint injury
☐ Osteoporosis ☐ Gout
☐ Rashes ☐ Hives
☐ Psoriasis ☐ Eczema
☐ Seizures
☐ Tremor / hands ☐ Numbness
☐ Headaches
☐ Concentration prob ☐ Memory loss
☐ Depression
☐ Decreased life enjoyment
☐ Decreased work performance
☐ Thoughts of death ☐ Suicide
☐ Sleep problems – how long ____
how often_____ ☐ waking refreshed
☐ sleeping too much
☐ Anxiety ☐ Phobias
☐ Mental illness
☐ Sexual problems / enjoyment
☐ Rheumatic fever ☐ Measles
☐ Chicken pox ☐ Polio ☐ Mumps
☐ Tuberculosis ☐ German measles

☐ Herpes ☐ Aids / HIV ☐ STD
☐ Alcohol: oz. per week
☐ Coffee / Tea : cups per day
☐ Smoking – cig/day: #years
year quit_____
☐ Stroke ☐ Hair loss:
☐ Exercise:
☐ Street drugs:
MALES –Please complete:
Last PSA _____
FEMALES- Please complete:
Menstrual flow:
Days of flow: Length of cycle:
Date–1st date of last period:
☐ Pain / Bleeding during or after sex
Number of :
Pregnancies: Abortions:
Miscarriages: Live births:
Birth control method:
☐ Flushing / Menopause
Date of last PAP test::
☐ Normal ☐ Abnormal
Date of last mammogram:
☐ Normal ☐ Abnormal

HEALTH CONCERNS YOU WISH TO DISCUSS