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History & Physical

Name _____
Date _____ SS# _____
Address _____
Occupation _____ Phone (Home) _____
(Work) _____ Date of Birth _____
Chief Complaint _____
Insurance# _____

Hospitalization or Surgery

Date	Reason	Date	Reason

Drug Allergies

Medications

Vaccine	Year of Last	Vaccine	Year of Last	Test/Exam	Year of Last	Test/Exam	Year of Last
Tetanus		Pneumonia		Rectal/Stool		Tuberculosis	
Flu		Other_____		Cholesterol		Other_____	

Medical History

- ☐ Abdominal Pain - *Chronic* _____
- ☐ Allergies/Hayfever _____
- ☐ Anemia ☐ Bruise Easily _____
- ☐ Ankles - *Swollen* _____
- ☐ Appetite - *Loss of* _____
- ☐ Arthritis/Rheumatism _____
- ☐ Asthma/Wheezing _____
- ☐ Back Pain - *Recurrent* _____
- ☐ Bone Fracture/Joint Injury _____
- ☐ Bowel Habits - *Change in* _____
- ☐ Bronchitis/Chronic Cough _____
- ☐ Cancer _____
- ☐ Chest Pain _____
- ☐ Convulsions/Seizures _____
- ☐ Diabetes _____
- ☐ Diarrhea ☐ Constipation _____
- ☐ Diphtheria _____
- ☐ Diverticulosis ☐ Crohn's/Colitis _____
- ☐ Dizziness/Fainting _____
- ☐ Ear Infections - *Frequent* _____
- ☐ Ear - *Ringing in* _____
- ☐ Eye Infections _____
- ☐ Fatigue - *Chronic* _____
- ☐ Foot Pain ☐ Cold Numb Feet _____
- ☐ Gall Bladder Trouble _____
- ☐ Gout _____
- ☐ Hair Loss _____
- ☐ Headaches - *Frequent* _____
- ☐ Heart Murmur _____
- ☐ Hemorrhoids _____
- ☐ Hernia _____
- ☐ High Blood Pressure _____
- ☐ Indigestion or Heartburn _____
- ☐ Infections - *Frequent* _____
- ☐ Jaundice/Hepatitis _____
- ☐ Kidney Stones _____
- ☐ Lactose Intolerance _____
- ☐ Leg Pain - *Walking* _____
- ☐ Memory Loss _____
- ☐ Mental Illness _____
- ☐ Moodiness - *Excessive* _____
- ☐ Muscle Weakness _____
- ☐ Nausea/Vomiting - *Persistent* _____
- ☐ Nervousness ☐ Depression _____
- ☐ Nose Bleeds _____
- ☐ Numbness/Tingling Sensations _____
- ☐ Osteoporosis _____
- ☐ Phobias _____
- ☐ Pneumonia _____
- ☐ Prostate Disease _____
- ☐ Psoriasis ☐ Eczema _____
- ☐ Rashes ☐ Hives _____
- ☐ Sexual/Menstrual Dysfunction _____
- ☐ Sinus Trouble _____
- ☐ Stools - *Bloody or Tarry* _____
- ☐ Stroke _____
- ☐ Swallowing Difficulty _____
- ☐ Tetanus _____
- ☐ Throat - Sore - *Frequent* _____
- ☐ Thyroid Disease _____
- ☐ Tremor/Hands Shaking _____
- ☐ Ulcers - *Peptic* _____
- ☐ Urethral Discharge _____
- Urination-☐ Overnight > than twice
  - ☐ Decrease in Force/Flow
  - ☐ Painful ☐ Loss of Control
- ☐ Urine - *Blood In* _____
- ☐ Varicose Veins/Phlebitis _____
- ☐ Venereal Disease _____
- ☐ Vision - *Failing* _____
- ☐ Weight Loss - *Recent* _____
- ☐ Chicken Pox ☐ Polio ☐ Mumps
- ☐ Measles ☐ Rubella ☐ Rheumatic Fever
- ☐ Scarlet Fever ☐ Tuberculosis ☐ Herpes
- ☐ Other _____
- ☐ Other _____

Females - *Please Complete*
Pregnant? ☐ Yes ☐ No
Planning Pregnancy? ☐ Yes ☐ No
Menstrual Flow:
☐ Regular ☐ Irregular ☐ Pain/Cramps
___Days of Flow ___Length of Cycle
Date-1st day of last period_____
☐ Pain/Bleeding during or after sex
Number of:
___Pregnancies ___Abortions
___Miscarriages ___Live Births
Birth Control Method_____
B.C. Pill (Name) _____
☐ Flushing/Menopause
Date of Last PAP Test _____
☐ Normal ☐ Abnormal
Date of Last Mammogram _____ ☐
☐ Normal ☐ Abnormal

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Hair Loss	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Other_____						

Habits

- ☐ Alcohol: Type _____
  Amount _____
- ☐ Coffee: Cups Daily _____
  Other Caffeine _____
  _____
- ☐ Diet: Salt Intake _____
  Fat Intake _____
  Other _____
- ☐ Exercise Routine: _____
  _____
- ☐ Sleep: Difficulty Falling Asleep _____
  Continuity Disturbances _____
  Early Morning Awakening _____
  Daytime Drowsiness _____
  Other _____
- ☐ Smoke: Packs Daily _____
  How Long _____
  Interested in Stopping? _____