

HISTORY & PHYSICAL

DATE



NAME _____ MARITAL STATUS M 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 CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) EPILEPSY	6) THYROID DISEASE	11) OSTEOPOROSIS	16) LIPID DISORDER
2) MIGRAINE	7) HAYFEVER	12) ARTHRITIS	17) ALCOHOLISM
3) MENTAL ILL.	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	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION
<i>not including pregnancies</i>				

LIST ALL MEDICATIONS YOU ARE NOW TAKING	ALLERGIES	VACCINE	YEAR OF LAST	TEST / EXAM	YEAR OF LAST
		Tetanus / Td		Rectal/Stool	
		Influenza (FLU)		Cholesterol	
		Pneumonia		Eye	
		Hepatitis			
		Tuberculosis			

MEDICAL HISTORY MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

MAIN PROBLEMS 1) _____ 2) _____ 3) _____		
<input type="checkbox"/> Decreased hearing <input type="checkbox"/> Ringing in ear <input type="checkbox"/> Ear infections - frequent <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Fainting spells <input type="checkbox"/> Failing vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Double or blurred vision <input type="checkbox"/> Nose bleeds - recurrent <input type="checkbox"/> Sinus trouble <input type="checkbox"/> Sore throats - frequent <input type="checkbox"/> Hoarseness - prolonged <input type="checkbox"/> Hayfever / Allergies <input type="checkbox"/> Pneumonia / Pleurisy <input type="checkbox"/> Bronchitis / Chronic cough <input type="checkbox"/> Asthma / Wheezing <input type="checkbox"/> Shortness of breath: <input type="checkbox"/> on exertion <input type="checkbox"/> lying flat <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Irregular pulse <input type="checkbox"/> Palpitations <input type="checkbox"/> Leg pain - when walking <input type="checkbox"/> Varicose veins / Phlebitis <input type="checkbox"/> Cold numb feet	<input type="checkbox"/> Loss of appetite - recent <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Peptic ulcer <input type="checkbox"/> Persistent nausea / Vomiting <input type="checkbox"/> Abdominal pain- chronic <input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Jaundice / Hepatitis <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's / Colitis <input type="checkbox"/> Bloody or tarry stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia Urination - Overactive Bladder <input type="checkbox"/> Overnight > than twice <input type="checkbox"/> More than 8 times / 24 hrs. <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> with leakage <input type="checkbox"/> Decrease in force/flow <input type="checkbox"/> Painful <input type="checkbox"/> Stress incontinence-urine leakage with exercise / movement <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Urine infections - frequent <input type="checkbox"/> Sexually transmitted diseases <input type="checkbox"/> Weight-loss <input type="checkbox"/> Gain-recent <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily <input type="checkbox"/> Blood transfusions	<input type="checkbox"/> Cancer <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tremor / hands shaking <input type="checkbox"/> Numbness / tingling sensations <input type="checkbox"/> Headaches - frequent <input type="checkbox"/> Arthritis / Rheumatism <input type="checkbox"/> Back pain - recurrent <input type="checkbox"/> Bone fracture / joint injury <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Foot pain <input type="checkbox"/> Gout <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Sleeping or concentration difficulty <input type="checkbox"/> Depression <input type="checkbox"/> Nervousness <input type="checkbox"/> Agitation <input type="checkbox"/> Memory loss <input type="checkbox"/> Moodiness <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Phobias <input type="checkbox"/> Mental illness <input type="checkbox"/> Feelings of worthlessness <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes <input type="checkbox"/> Aids / HIV
<input type="checkbox"/> Alcohol _____ oz. per week <input type="checkbox"/> Coffee / Tea _____ cups per day <input type="checkbox"/> Smoking _____ cig/day #years year quit _____ <input type="checkbox"/> Exercise _____ <input type="checkbox"/> Street Drugs _____ <input type="checkbox"/> Accupuncture / tatoos _____ Hair loss: <input type="checkbox"/> progressive <input type="checkbox"/> recent FEMALES - Please complete Menstrual flow: <input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain / Cramps Days of Flow _____ Length of cycle _____ Date -1st day of last period _____ <input type="checkbox"/> Pain / Bleeding during or after sex Number of: Pregnancies _____ Abortions _____ Miscarriages _____ Live births _____ Birth control method _____ B.C. pill (name) _____ <input type="checkbox"/> Flushing / Menopause Date of last PAP test _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Date of last Mammogram _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		

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