HISTORY & PHYSICAL

DAT

NAME

M F MARITAL STATUS S M W D SEP

DATE OF BIRTH

Formedic

ADDRESS

PHONE (H) (O)

OCCUPATION/ EMPLOYER

INSURANCE

PAGE # CHART #

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 *not including pregnancies*

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

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)

- ☐ Decreased hearing
- ☐ Ringing in ear
- ☐ Ear infections - *frequent*
- ☐ Dizzy spells ☐ Fainting spells
- ☐ Failing vision ☐ Eye pain
- ☐ Double or blurred vision
- ☐ 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 - *when walking*
- ☐ Varicose veins / Phlebitis
- ☐ Cold numb feet

- ☐ Loss of appetite - *recent*
- ☐ Difficulty swallowing
- ☐ Heartburn ☐ Peptic ulcer
- ☐ *Persistent* nausea / Vomiting
- ☐ Abdominal pain- *chronic*
- ☐ Gall bladder trouble
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids ☐ Hernia

Urination - Overactive Bladder
- ☐ Overnight > than twice
- ☐ More than 8 times / 24 hrs.
- ☐ Urgency to urinate ☐ with leakage
- ☐ Decrease in force/flow ☐ Painful
- ☐ Stress incontinence-urine leakage with exercise / movement
- ☐ Blood in urine ☐ Kidney stones
- ☐ Urine infections - *frequent*
- ☐ Sexually transmitted diseases
- ☐ Weight-loss ☐ Gain-*recent*
- ☐ Anemia ☐ Bruise easily
- ☐ Blood transfusions

- ☐ Cancer ☐ Chronic fatigue
- ☐ Diabetes ☐ Thyroid disease
- ☐ Seizures ☐ Stroke
- ☐ Tremor / hands shaking
- ☐ Numbness / tingling sensations
- ☐ Headaches - *frequent*
- ☐ Arthritis / Rheumatism
- ☐ Back pain - *recurrent*
- ☐ Bone fracture / joint injury
- ☐ Osteoporosis
- ☐ Foot pain ☐ Gout
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Sleeping or concentration difficulty
- ☐ Depression ☐ Nervousness
- ☐ Agitation ☐ Memory loss
- ☐ Moodiness ☐ Suicidal thoughts
- ☐ Phobias ☐ Mental illness
- ☐ Feelings of worthlessness
- ☐ Rheumatic Fever ☐ Scarlet Fever
- ☐ Chicken Pox ☐ Polio ☐ Mumps
- ☐ Measles ☐ German Measles
- ☐ Tuberculosis ☐ Herpes
- ☐ Aids / HIV

- ☐ Alcohol ___ oz. per week
- ☐ Coffee / Tea ___ cups per day
- ☐ Smoking ___ cig/day ___ #years ___ year quit
- ☐ Excercise
- ☐ Street Drugs
- ☐ Accupuncture / tatoos

Hair loss: ☐ progressive ☐ recent

FEMALES - *Please complete*

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ 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