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History & Physical

Name _____ Date _____

Occupation _____

Date of Birth _____

Chief Complaint _____

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?_____