HISTORY & PHYSICAL

DATE:

NAME ____ ☐M ☐F MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP DATE OF BIRTH______________________

ADDRESS____ PHONE ____________________________

OCCUPATION/
EMPLOYER ____ INSURANCE__________________________________

FAMILY HISTORY

IF ANY BLOODRELATIVE HAS SUFFERED ANY OF THE FOLLOWING – PLEASE CIRCLE THE # 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) Other

HOSPITAL ADMISSIONS

Not including pregnancies

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING **ALLERGIES**

____

____ **SUPPLIMENTS**

____

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VACCINE	YEAR OF LAST	TEST/EXAM	YEAR OF LAST
Tetanus / Td	_____	Rectal/Stool	_____
Influenza(flu)	______	Cholesterol	_____
Pneumonia	_______	Eye	__________
Hepatitis	_________	Dental	_________
Tuberculosis			

MEDICAL HISTORY

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

MAIN PROBLEM

☐ Hearing problem ☐Ringing in ear
☐ Dizzy spells ☐Fainting spells
☐ Vision problems ☐ Eye pain
☐ Nose bleeds-*recurrent*
☐ Sinus trouble
☐ Sore throats-*frequent*
☐ Hoarseness-*prolonged*
☐ Hayfever/Allergies
☐ Pneumonia/Pleurisy
☐ Bronchitis/Chronic cough
☐ Asthma/Wheezing
Short of Breath
☐ Exertion ☐ Lying flat
☐ Chest pain
☐ High blood pressure
☐ Heart murmur ☐ Swollen ankles
☐ Irregular pulse ☐ Palpitations
☐ Leg pain ☐Cold numb feet
☐ Varicose veins/Phlebitis

☐ Loss of appetite ☐Difficulty swallowing
☐ Heartburn ☐ Peptic ulcer
☐ Nausea/Vomiting ☐Gallbladder dis
☐ Abdominal pain-*chronic*
☐ Jaundice/Hepatitis
☐ Diarrhea ☐Constipation
☐ Diverticulosis ☐ Crohn's / Colitis
☐ Bloody or tarry stools
☐ Hemorrhoids ☐ Hernia
☐ Urination-Overactive Bladder
☐ Overnight > than twice
☐ More than 8 times / 24hrs
☐ Urgency to urinate ☐with leakage
☐ Decrease in force/flow ☐painful
☐ Stress incontinence urine leakage
☐ With exercise / movement
☐ Blood in urine
☐ Urine infections
☐ Weight-loss- gain
☐ Appetite ☐ Nutrition problems
☐ Anemia ☐ Bruise easily
☐ Cancer ☐ Easily fatigued

☐ Diabetes ☐Thyroid disease
☐ Seizures ☐Stroke
☐ Tremor/hands shaking
☐ Numbness/tingling sensation
☐ Headaches-*frequent*
☐ Arthritis/Rheumatism
☐ Back pain-*recurrent*
☐ Bone fracture/joint injury
☐ Osteoporosis ☐Gout
☐ Rashes ☐ Hives
☐ Psoriasis ☐ Eczema
☐ Concentration prop ☐Sleep problems
☐ Depression ☐Nervousness
☐ Moodiness ☐Suicidal thoughts
☐ Memory loss ☐ Mental illness
☐ Rheumatic Fever ☐Measles
☐ Chicken Pox ☐Polio ☐Mumps
☐ Tuberculosis ☐German measles
☐ Herpes ☐Aids / HIV ☐ STD
☐ Sexual problems / enjoyment

☐ Decreased life enjoyment
☐ Decreased work performance
☐ Alcohol_______oz per week
☐ Coffee/tea_______cups/day
☐ Smoking cig/day_______
#years__ __ year quit_____
☐ Exercise______
☐ Street Drugs
FEMALES –Please complete
Menstrual flow
☐ Reg ☐ Irreg ☐ Pain/cramps
Days of flow________
Length of cycle______
1st day of last period ____
☐ Pain/Bleeding during/ after sex
# of pregnancies ☐Abortion
☐ Miscarriages ☐Live births
☐ Birth control method
☐ Flushing/Menopause
Date of last PAP test ______
☐ Normal ☐ Abnormal
Date of last mammogram___
☐ Normal ☐ Abnormal

☐ During the past 2 weeks, have you ever felt down, depressed or hopeless?
☐ During the past 2 weeks, have you felt a lack of pleasure or interest in doing things?

SYNOPSIS

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