HISTORY & PHYSICAL FORM **DATE: _____**

Patient name: _____Date of birth: _____

Current medications:

Drug name: _____ Dose: _____ How often: _____
Drug name: _____ Dose: _____ How often: _____
Drug name: _____ Dose: _____ How often: _____
Drug name: _____ Dose: _____ How often: _____

Family History: If any blood relative has suffered any of the following, please mark them and which family member:

( ) Epilepsy: _____( ) Thyroid Disease:_____ ( ) Osteoporosis:_____ ( ) Lipid disorder: _____
( ) Migraines: _____( ) Hay fever:_____ ( ) Arthritis:_____ ( )Alcoholism:_____
( ) Mental Illness:_____( ) Asthma:_____ ( ) Heart Disease:_____ ( ) Cancer:_____
( ) Glaucoma:_____( ) Anemia:_____ ( ) Stroke:_____ ( ) Diabetes:_____
( ) Bleeding:_____( ) Hypertension:_____ ( ) Arthritis:_____ ( ) Immunity:_____

Hospital admissions: (not including pregnancy)

Year: _____ Illness/operation: _____
Year: _____ Illness/operation: _____
Year: _____ Illness/operation: _____

Allergies: _____

( )Alcohol _____oz/week ( )Smoking ____cig/day # years: ____, # of years quit: ____( )Coffee/Tea ____cups per day_____

Vaccine/immunizations: (year of your last one)
Tetanus/Td: _____ Flu: _____ Pneumonia: _____ Hep B: _____ Hep A: _____ TB: _____

Medical History:

Please circle any current or previous medical problems and specify/clarify below.

( ) Decreased hearing	( ) Loss of appetite	( ) Diabetes	( ) Ringing in ears
( ) Seizures	( ) Difficulty swallowing	( ) Tremor/hands shaking	( ) Ear infections
( ) Heartburn	( ) Peptic ulcer	( ) Dizzy spells	( ) Fainting spells
( ) Muscle weakness	( ) Failing vision	( ) Eye pain	( ) Abdominal pain
( ) Headaches	( ) Persistent vomiting	( ) Persistent nausea	( ) Double vision
( ) Blurred vision	( ) Gall bladder trouble	( ) Numbness	( ) Tingling
( ) Jaundice	( ) Hepatitis	( ) Stroke	( ) Nose bleeds
( ) Arthritis	( ) Back pain	( ) Bone fracture	( ) Joint pain
( ) Gout	( ) Diverticulosis	( ) Change in bowel habits	( ) Osteoporosis
( ) Crohn's/Colitis	( ) Cold numb feet	( ) Pneumonia/Pleurisy	( ) Hemorrhoids
( ) Hernia	( ) Rashes	( ) Hives	( ) Eczema
( ) Psoriasis	( ) Chronic cough	( ) Kidney stones	( ) Sleeping difficulty
( ) Asthma/wheezing	( ) Depression	( ) Nervousness	( ) Agitation
( ) Memory loss	( ) Overnight urination	( ) Painful urination	( ) Palpitations
( ) Suicidal thoughts	( ) Moodiness	( ) Phobias	( ) Loss of urine control
( ) Shortness of breath	( ) STD/STI	( ) Mental illness	( ) High blood pressure
( ) Urethral discharge	( ) Heart murmur	( ) Anemia	( ) Cancer
( ) Irregular pulse	( ) Weight loss	( ) Phlebitis/Varicose vein	( ) Weight gain
( ) Chronic fatigue	( ) Leg pain	( ) Bruise easily	( ) Polio
( ) Rheumatic fever	( ) Scarlet fever	( ) Herpes	( ) German measles
( ) Herpes	( ) Chicken pox	( ) Tuberculosis	( ) Recent hair loss

Female patients ONLY:

( ) Pain/bleeding during/after sex ( ) Menopause Birth control method: _____, pill: _____
Days of flow: _____ Length of cycle: _____First date of last period: _____
Number of pregnancies: _____ Abortions: _____ Miscarriages: _____ Live births: _____
Date of last Pap test: _____, ( ) Normal ( ) Abnormal
Date of last mammogram: _____, ( ) Normal ( ) Abnormal
Additional information:

_____

PLEASE USE BACK OF FORM TO ADD ADDITIONAL INFORMATION