

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:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Epilepsy: _____ | <input type="checkbox"/> Thyroid Disease: _____ | <input type="checkbox"/> Osteoporosis: _____ | <input type="checkbox"/> Lipid disorder: _____ |
| <input type="checkbox"/> Migraines: _____ | <input type="checkbox"/> Hay fever: _____ | <input type="checkbox"/> Arthritis: _____ | <input type="checkbox"/> Alcoholism: _____ |
| <input type="checkbox"/> Mental Illness: _____ | <input type="checkbox"/> Asthma: _____ | <input type="checkbox"/> Heart Disease: _____ | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Glaucoma: _____ | <input type="checkbox"/> Anemia: _____ | <input type="checkbox"/> Stroke: _____ | <input type="checkbox"/> Diabetes: _____ |
| <input type="checkbox"/> Bleeding: _____ | <input type="checkbox"/> Hypertension: _____ | <input type="checkbox"/> Arthritis: _____ | <input type="checkbox"/> 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.

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