HISTORY & PHYSICAL

NAME _____
DATE _____ SS# _____
ADDRESS _____
OCCUPATION _____ PHONE (HOME) _____
(WORK) _____ DATE OF BIRTH _____
CHIEF COMPLAINT _____
INSURANCE# _____

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

- ☐ RINGING IN EAR _____
- ☐ EAR INFECTIONS - *FREQUENT* _____
- ☐ DIZZINESS/FAINTING _____
- ☐ HAIR LOSS _____
- ☐ FAILING VISION _____
- ☐ EYE INFECTIONS _____
- ☐ NOSE BLEEDS _____
- ☐ SINUS TROUBLE _____
- ☐ SORE THROATS - *FREQUENT* _____
- ☐ HAYFEVER/ALLERGIES _____
- ☐ PNEUMONIA _____
- ☐ BRONCHITIS/CHRONIC COUGH _____
- ☐ ASTHMA/WHEEZING _____
- ☐ CHEST PAIN _____
- ☐ HAIR LOSS _____
- ☐ HIGH BLOOD PRESSURE _____
- ☐ HEART MURMUR _____
- ☐ SWOLLEN ANKLES _____
- ☐ LEG PAIN - *WALKING* _____
- ☐ VARICOSE VEINS/PHLEBITIS _____
- ☐ LOSS OF APPETITE _____
- ☐ DIFFICULTY SWALLOWING _____
- ☐ INDIGESTION OR HEARTBURN _____
- ☐ PERSISTENT NAUSEA/VOMITING _____
- ☐ PEPTIC ULCERS _____
- ☐ ABDOMINAL PAIN - *CHRONIC* _____
- ☐ GALL BLADDER TROUBLE _____
- ☐ JAUNDICE/HEPATITIS _____
- ☐ CHANGE IN BOWEL HABITS _____
- ☐ DIARRHEA ☐ CONSTIPATION _____
- ☐ DIVERTICULOSIS ☐ CROHN'S/COLITIS _____
- ☐ BLOODY OR TARRY STOOLS _____
- ☐ HEMORRHOIDS _____
- ☐ HERNIA _____
- ☐ URINE INFECTIONS - *FREQUENT* _____
- ☐ BLOOD IN URINE _____
- URINATION-☐ OVERNIGHT > THAN TWICE
  - ☐ PAINFUL ☐ LOSS OF CONTROL
  - ☐ DECREASE IN FORCE/FLOW
- ☐ KIDNEY STONES _____
- ☐ VENEREAL DISEASE _____
- ☐ URETHRAL DISCHARGE _____
- ☐ CHRONIC FATIGUE _____
- ☐ WEIGHT LOSS - *RECENT* _____
- ☐ ANEMIA ☐ BRUISE EASILY _____
- ☐ CANCER _____
- ☐ DIABETES _____
- ☐ THYROID DISEASE _____
- ☐ CONVULSIONS/SEIZURES _____
- ☐ STROKE _____
- ☐ TREMOR/HANDS SHAKING _____
- ☐ MUSCLE WEAKNESS _____
- ☐ NUMBNESS/TINGLING SENSATIONS _____
- ☐ HEADACHES - *FREQUENT* _____
- ☐ ARTHRITIS/RHEUMATISM _____
- ☐ OSTEOPOROSIS _____
- ☐ BACK PAIN - *RECURRENT* _____
- ☐ BONE FRACTURE/JOINT INJURY _____
- ☐ GOUT _____
- ☐ FOOT PAIN ☐ COLD NUMB FEET _____
- ☐ RASHES ☐ HIVES _____
- ☐ PSORIASIS ☐ ECZEMA _____
- ☐ NERVOUSNESS ☐ DEPRESSION _____
- ☐ MEMORY LOSS _____
- ☐ MOODINESS - *EXCESSIVE* _____
- ☐ PHOBIAS _____
- ☐ MENTAL ILLNESS _____
- ☐ LACTOSE INTOLERANCE _____
- ☐ PROSTATE DISEASE _____
- ☐ SEXUAL/MENSTRUAL DYSFUNCTION _____
- ☐ FREQUENT INFECTIONS _____
- ☐ DIPHTHERIA _____
- ☐ TETANUS _____
- ☐ 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	☐	☐	☐	☐	☐	☐
GLAUCOMA	☐	☐	☐	☐	☐	☐
EPILEPSY/CONVULSIONS	☐	☐	☐	☐	☐	☐
HAIR LOSS	☐	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐	☐

	FATHER	MOTHER	CHILDREN	SIBLINGS	FATHER'S PARENTS	MOTHER'S PARENTS
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐	☐	☐
MENTAL ILLNESS	☐	☐	☐	☐	☐	☐
MIGRAINE	☐	☐	☐	☐	☐	☐
OSTEOPOROSIS	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐
THYROID DISEASE	☐	☐	☐	☐	☐	☐
OTHER_____						

HABITS

- ☐ ALCOHOL: TYPE _____
  AMOUNT_____
- ☐ DIET: SALT INTAKE _____
  FAT INTAKE _____
  OTHER _____
- ☐ SLEEP: DIFFICULTY FALLING ASLEEP _____
  CONTINUITY DISTURBANCES _____
  EARLY MORNING AWAKENING _____
  DAYTIME DROWSINESS _____
  OTHER_____
- ☐ SMOKE: PACKS DAILY _____
  HOW LONG_____
  INTERESTED IN STOPPING?_____
- ☐ EXERCISE ROUTINE: _____
- ☐ COFFEE: CUPS DAILY_____
  OTHER CAFFEINE _____

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