HISTORY AND PHYSICAL

Name _____ SS# _____ Date _____

Address _____

Phone (Home) _____ (Work) _____ Birth Date _____

Chief Complaint

DRUG ALLERGIES

_____

_____

CURRENT MEDS

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

	Father	Mother	Mother's Parents	Father's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY Pregnant? ❑ Yes ❑ No Planning Pregnancy? ❑ Yes ❑ No

PAST MEDICAL HISTORY

- ❑ Tetanus _____ ☐
- ❑ Diptheria _____ ☐
- ❑ Polio _____ ☐
- ❑ Rubella _____ ☐
- ❑ Measles _____ ☐
- ❑ Pneumonia _____ ☐
- ❑ Mumps _____ ☐
- ❑ Rheumatic Fever _____
- ❑ Venereal Disease _____
- ❑ Bronchitis _____
- ❑ Hepatitis _____
- ❑ Anemia _____
- ❑ Scarlet Fever _____
- ❑ Allergies/Hay Fever _____
- ❑ Asthma _____
- ❑ Chronic Rashes _____
- ❑ Ulcer _____
- ❑ GI Disorder _____
- ❑ Gall Bladder Disease _____
- ❑ Prostate Disease _____
- ❑ Bowel Irregularity _____
- ❑ Sexual/Menstrual Dysfunction _____
- ❑ Arthritis _____
- ❑ Nervousness _____
- ❑ Depression _____
- ❑ Gout _____
- ❑ Frequent Infections _____
- ❑ Shortness Of Breath _____
- ❑ Heart Palpitations _____
- ❑ Heart Murmur _____
- ❑ Chest Pain _____
- ❑ Dizziness/Fainting _____
- ❑ Peripheral Vascular Disease _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

HABITS

- ❑ Smoke: Packs Daily _____ How long _____ When Stopped _____
- ❑ Exercise routine _____ ❑ Coffee: Cups daily _____ Other caffeines _____
- ❑ Alcohol: Type/Amount _____ ❑ Sleep Pattern _____
- ❑ Diet: Salt _____ ❑ Cholesterol _____