History and Physical

Name_____ Date of Visit_____ Marital Status_____

Referring Doctor/NP/PA_____Date of Birth_____ Age_____

Chief Complaint/ History of Present Illness _____

_____

Drug Allergies_____

Current Medications Include Any Herbals or Natural Supplements

Medication	Dose	Frequency	Medication	Dose	Frequency

Past Medical History

Please check if you have ever had any of the following:

☐ Alcoholism	☐ Congenital Heart disease	☐ Gout	☐ Lung Disease
☐ Allergies/hay fever	☐ Congestive heart failure	☐ Heart Attack	☐ Pacemaker
☐ Anemia	☐ Defibrillator	☐ Hepatitis	☐ Reflux/GERD
☐ Anxiety/Depression	☐ Diabetes	☐ Heart Murmur	☐ Rheumatic Fever
☐ Arthritis	☐ Difficulty Swallowing	☐ Hiatal Hernia	☐ Seizures
☐ Asthma	☐ Diverticulitis	☐ High blood pressure	☐ Skin Disease
☐ Blood Transfusions	☐ Diverticulosis	☐ Irregular heartbeat	☐ Stroke
☐ Bladder Disorder	☐ Electronic Stimulator	☐ Kidney disease	☐ Thyroid disease
☐ Cancer	☐ Elevated Cholesterol	☐ Kidney Stones	☐ Tuberculosis
☐ Chest pain/angina	☐ Gallbladder	☐ Liver Disease	☐ Ulcer
☐ Colon Polyps	☐ Glaucoma		
Additional Past Medical History:			

Hospitalization or Surgery

Date	Reason

Women Only: Pregnant ☐ Yes ☐ No Planning Pregnancy ☐ Yes ☐ No

Smoke:☐ Yes ☐ No # Packs daily_____ How Long? _____ Stopped Smoking when?_____

Do you exercise? ☐ Yes ☐ No Caffeine use ☐ Yes ☐ No Type _____Amt._____

Alcohol: ☐ Yes ☐ No Type/Amount_____Drug Use? ☐ Yes ☐ No Type:_ _____

(OVER)

Family History	Father	Mother	Father's Parents	Mother's Parents	Siblings
Asthma			☐ M ☐ F	☐ M ☐ F	
Heart Disease			☐ M ☐ F	☐ M ☐ F	
High Blood Pressure			☐ M ☐ F	☐ M ☐ F	
Stroke			☐ M ☐ F	☐ M ☐ F	
Colon Cancer			☐ M ☐ F	☐ M ☐ F	
Colon Polyps			☐ M ☐ F	☐ M ☐ F	
Other Cancers (state type)			☐ M ☐ F	☐ M ☐ F	
Diabetes			☐ M ☐ F	☐ M ☐ F	
Stomach Ulcer			☐ M ☐ F	☐ M ☐ F	
Kidney Disease			☐ M ☐ F	☐ M ☐ F	

Review Of Systems

GENERAL
☐ chills
☐ fevers
☐ tired (malaise)
☐ weight loss
☐ night sweats

HEENT
☐ double vision
☐ ear infections
☐ eye pain
☐ nasal congestion
☐ sinus infection
☐ sore throat
☐ headache
☐ blurred vision
☐ dizziness
☐ ringing in ears
☐ hearing loss
☐ nose bleeds
☐ hoarseness

RESPIRATORY
☐ shortness of breath
☐ frequent cough
☐ pain on breathing
☐ wheezing
☐ coughing blood
☐ yellow/green sputum

CARDIOVASCULAR
☐ chest pain
☐ shortness of breath
☐ ankle swelling
☐ palpitations
☐ heart attack
☐ irregular heartbeats
☐ difficulty lying flat

GASTROINTESTINAL
☐ abdominal pain
☐ change in bowel habits
☐ constipation
☐ diarrhea
☐ difficulty swallowing
☐ heartburn
☐ vomiting blood
☐ blood in bowel movement
☐ loss of appetite
☐ black tarry stool
☐ nausea
☐ reflux
☐ vomiting

GENITOURINARY
☐ pain on urination
☐ bloody urine
☐ frequent urination
☐ incontinence
☐ urinary retention
☐cloudy urine
☐ decrease in urine flow

METABOLIC
☐ cold intolerance
☐ excessive thirst
☐ heat intolerance
☐ gynecomastia
☐ diabetes
☐ thyroid problems
☐ excessive hair
☐ change in skin color/texture

HEMATOLOGIC
☐ easy bleeding
☐ easy bruising
☐ swollen lymph nodes

NEUROLOGICAL
☐ dizziness
☐ headache
☐ loss of sensation
☐ numbness
☐ tremors
☐ feeling of whirling or spinning
☐ seizures
☐ stroke
☐ muscle weakness
☐ loss of balance
☐ speech difficulties

PSYCHIATRIC
☐ anxiety
☐ depression
☐ increased stress
☐ difficulty sleeping
☐ hearing voices
☐ mood swings
☐ suicidal thoughts

INTEGUMENTARY
☐ contact allergy
☐ hives
☐ itching
☐ rash
☐ yellow/jaundice
☐ easy bruising
☐ skin cancer

MUSCULOSKELETAL
☐ back pain
☐ muscle pain
☐ joint pain
☐ joint swelling
☐ decrease in mobility

IMMUNOLOGIC
☐ asthma
☐ chemicals at work
☐ food allergies
☐ immunosuppression
☐ seasonal allergies
☐ allergy shots
☐ immunoglobulin treatment

IMMUNIZATIONS

☐ Yes ☐ No

Pneumococcal
Year ( )

☐ Yes ☐ No

Flu
Year ( )

☐ Yes ☐ No

Hepatitis A
Year ( )

☐ Yes ☐ No

HPV
Year ( )

☐ Yes ☐ No

Hepatitis B
Year ( )

☐ Yes ☐ No

Shingles
Year ( )

☐ Yes ☐ No

Hepatitis A&B
Year ( )