

HISTORY & PHYSICAL

Name _____ SSN# _____ Date _____
 Address _____ Occupation _____
 Phone (home) _____ Work _____ Date of Birth _____ Age _____
 Chief Complaint _____

Name

DRUG ALLERGIES

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/ Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT MEDS

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

PAST HISTORY (have or had)

- | | | |
|---|---|---|
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Gallbladder Disease _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Shortness of Breath _____ | <input type="checkbox"/> Prostate Problems _____ | <input type="checkbox"/> Gout _____ |
| <input type="checkbox"/> Heart Palpitations _____ | <input type="checkbox"/> Bowel Irregularity _____ | <input type="checkbox"/> Scarlet Fever _____ |
| <input type="checkbox"/> Heart Murmur _____ | <input type="checkbox"/> Incontinence _____ | <input type="checkbox"/> Chronic Rashes _____ |
| <input type="checkbox"/> Chest Pain _____ | <input type="checkbox"/> Overactive Bladder _____ | <input type="checkbox"/> Rheumatic _____ |
| <input type="checkbox"/> Dizziness/ Fainting _____ | <input type="checkbox"/> Frequent Urination _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Vascular Disease _____ | <input type="checkbox"/> Sexual Menstrual Dysfunction _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Allergies/ Hay Fever _____ | <input type="checkbox"/> STD _____ | <input type="checkbox"/> Rubella _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Frequent Infections _____ | <input type="checkbox"/> Polio _____ |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Hepatitis (type) _____ | <input type="checkbox"/> Diphtheria _____ |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Tetanus _____ |
| <input type="checkbox"/> Ulcer _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> GI Disorder _____ | <input type="checkbox"/> Osteoporosis _____ | |
| <input type="checkbox"/> Lactose intolerance _____ | <input type="checkbox"/> Nervousness/ Anxiety _____ | |

HABITS

- | | | |
|--|---|--|
| <input type="checkbox"/> Smoke Packs Daily _____
How Long? _____
Interested in stopping? _____ | <input type="checkbox"/> Coffee: Cups Daily _____
Other Caffeine _____ | <input type="checkbox"/> Birth Control Method: _____ |
| | <input type="checkbox"/> Alcohol: Type _____ | |
| Exercise routine _____ | Amount _____ | |

Illicit Drugs (Past or Present) _____

REVIEW OF SYMPTOMS

- | | | |
|---|--|---|
| <input type="checkbox"/> Nerve _____ | <input type="checkbox"/> Stomach _____ | <input type="checkbox"/> Heart _____ |
| <input type="checkbox"/> Kidney/ Bladder _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Arthritis/ Joint _____ |
| <input type="checkbox"/> Circulation _____ | <input type="checkbox"/> Skin _____ | <input type="checkbox"/> Bleeding _____ |
| <input type="checkbox"/> Disability _____ | <input type="checkbox"/> Respiratory _____ | <input type="checkbox"/> Reproductive _____ |
| <input type="checkbox"/> Eyes, Ears, Nose, Throat _____ | | |