HISTORY & PHYSICAL

DATE

NAME

M F MARITAL STATUS S M W D SEP

DATE OF BIRTH

ADDRESS

PHONE (H) (O)

OCCUPATION/ EMPLOYER

INSURANCE

PAGE #

CHART #

FAMILY HISTORY

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) Epilepsy	6) Hay fever	11) Arthritis	16) Cancer
2) Migraine	7) Asthma	12) Heart disease	17) Restless leg syndrome
3) Glaucoma	8) Anemia	13) Stroke	18) Depression
4) Diabetes	9) Bleeding disorder	14) Hypertension	19) Alcoholism
5) Thyroid disease	10) Osteoporosis	15) Lipid disorder	20) Mental illness

HOSPITAL ADMISSIONS

not including pregnancies

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING

ALLERGIES

SUPPLEMENTS

VACCINE	YEAR OF LAST	VACCINE	YEAR OF LAST
Tetanus / Td		MMR Measles Mumps Rubella	
Influenza (flu)		Meningitis	
Pneumonia		Chicken pox	
Hepatitis A		HPV	
Hepatitis B		Shingles	
Whooping C			

MEDICAL HISTORY

MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

MAIN PROBLEM

Hearing problems Ringing in ear
Dizzy spells Fainting spells
Vision problems Eye pain
Date of last eye exam
Nose bleeds Sinus trouble
Sore throats - *frequent*
Hoarseness - *prolonged*
Hayfever / Allergies
Pneumonia / Pleurisy
Bronchitis / Chronic cough
Asthma / Wheezing
Date of last TB test
Shortness of breath:
on exertion lying flat
in the past week
affects work lifestyle
Chest pain High blood pressure
Date of last cholesterol test
Heart murmur Swollen ankles
Irregular pulse Palpitations
Leg pain Cold numb feet
Varicose veins / Phlebitis
Appetite Difficulty swallowing
loss gain

Heartburn Peptic ulcer
Aspirin - arthritis - pain pills
Nausea / vomiting Gallbladder dis
Jaundice / Hepatitis
Diarrhea Constipation
Diverticulosis Crohn's / Colitis
Bloody or tarry stools
Test for blood in stool
Hemorrhoids Hernia
Urination - Overactive bladder
Overnight > than twice
More than 8 times / 24 hrs.
Urgency to urinate with leakage
Decrease in force/flow Painful
Stress incontinence-urine leakage with exercise / movement
Blood in urine Kidney stones
Urine infections Prostate prob
Bed wetting
Weight-loss gain
Anemia Bruise easily
Cancer Fatigue / loss of energy
Diabetes Thyroid disease

Arthritis / Rheumatism Back pain
Bone fracture / joint injury
Osteoporosis Gout
Rashes Hives
Psoriasis Eczema
Excessive sweating
Seizures Stroke
Tremor/hands Numbness
Headaches Memory loss
Depression Confusion
Decreased work performance
Sleep problems
for how long how often
sleeping - too little too much
waking refreshed yes no
Legs keep you up at night
Concentration problems
Difficulty with unfamiliar tasks
Thoughts of death suicide
Anxiety Mood swings Phobias
Mental illness
Sexual problems / enjoyment
Rheumatic fever Measles
Chicken pox Polio Mumps

Tuberculosis German measles
Herpes Aids / HIV
Sexually transmitted diseases - # of encounters
Alcohol oz. per week
Coffee / Tea cups per day
Smoking- cig/day # years
year quit
Exercise
Street drugs
Travel abroad

FEMALES - *Please complete*
Menstrual flow:
Reg. Irreg. 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
Flushing / Menopause
Date of last PAP test
Normal Abnormal
Date of last mammogram
Normal Abnormal

SYNOPSIS