HISTORY & PHYSICAL

NAME

CHIEF COMPLAINT

HOSPITALIZATION OR SURGERY		DRUG ALLERGIES	MEDICATIONS	YEAR	VACCINE OR TEST
DATE	REASON				
					Tetanus
					Flu
					Pneumonia
					Rectal
					Stool
					Cholesterol
					TB

HABITS (Circle appropriate answer)

ALCOHOL: Type Amount:

DIET: SALT INTAKE: Small Moderate Large

FAT INTAKE: Small Moderate Large

SLEEP: Difficulty falling asleep Yes No

Trouble staying asleep Yes No

Early morning awakening Yes No

Daytime drowsiness Yes No

SMOKE: Packs daily How long?

Interested in stopping? Yes No

EXERCISE: Daily 3-4/week Sometimes Rarely Never

CAFFEINE INTAKE: Coffee Tea Soft Drinks

Other None

WOMEN (circle appropriate answer)

PREGNANT? Yes No

PLANNING PREGNANCY? Yes No

MENSTRUAL FLOW? Regular Irregular

Pain/cramps ____Days of flow

____Length of cycle ________Last period

_____Pain/bleeding during or after sex

NUMBER OF: ____Pregnancies ____Abortions

______Miscarriages _____Live births

BIRTH CONTROL METHOD:______________________

NAME OF BIRTH CONTROL PILL:_________________

HYSTERECTOMY: Yes No Partial

MENOPAUSE: Yes No Hot Flashes

DATE OF LAST PAP TEST:______________________

Normal Abnormal

DATE OF LAST MAMMOGRAM:__________________

Normal Abnormal

NAME OF CLINIC WHERE LAST MAMMOGRAM

DONE: ______________________________________

MEDICAL HISTORY

___Ringing in the ear
___Ear infections--*frequent*
___Dizziness/fainting
___Failing vision
___Eye infections
___Nosebleeds
___Sinus trouble
___Hay fever/allergies
___Sore throat
___Pneumonia
___Bronchitis/chronic cough
___Asthma/wheezing
___Chest pain
___High blood pressure
___Heart murmur
___Swollen ankles
___Leg pain--*walking*
___Varicose veins
___Loss of appetite
___Peptic ulcers
___Jaundice/hepatitis
___Hernia
___Tuberculosis

___Cancer
___Diabetes
___Thyroid disease
___Hemorrhoids
___Rectal bleeding
___Persistent nausea/vomiting
___Abdominal pain--*chronic*
___Gallbladder trouble
___Change in bowel habits
___Diarrhea/constipation
___Bloody or tarry stools
___Diverticulitis/diverticulosis
___Difficulty swallowing
___Indigestion/heartburn
___Urine infections--*frequent*
___Blood in urine
___Urinating more than twice overnight
___Painful urination, loss of control, decrease in force or flow
___Kidney stones
___Scarlet fever

___Venereal disease
___Urethral discharge
___Chronic fatigue
___Weight loss--*recent*
___Anemia/easy bruising
___Convulsions/seizures
___Stroke
___Headaches--*frequent*
___Arthritis/rheumatism
___Osteoporosis
___Back pain--*recurrent*
___Bone/joint injury
___Gout
___Rheumatic fever
___Muscle weakness
___Numbness
___Tingling sensations
___Tremors/hands shaking

___Foot pain
___Cold numb feet
___Rashes/hives
___Psoriasis/eczema
___Depression
___Nervousness
___Memory loss
___Moodiness-*excess*
___Phobias
___Mental illness
___Lactose intolerance
___Prostate disease
___Sexual dysfunction
___Infections--*frequent*
___Diptheria/tetanus
___Chicken pox
___Polio, rubella
___Measles, mumps

FAMILY HISTORY

___Alcoholism
___Asthma
___Bleeding Disorder
___Cancer
___Diabetes
___Glaucoma

___Epilepsy/Convulsions
___Heart Disease
___High Blood Pressure
___Kidney Disease
___Mental Illness
___Migraine

___Osteoporosis
___Stroke
___Thyroid Disease
___Other