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HISTORY & PHYSICAL

Instructions: Please fill out the following forms completely in black or blue ink.

Name_____
DOB:_____

Marital Status: S_____ M_____ D_____ W_____

Reason for Visit:
_____

Allergies/Medication: No Known Drug Allergies _____ No known food allergies _____

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Please list any medication, dosage, & frequency you are currently taking (include over-the-counter):

_____
_____
_____
_____
_____
_____
_____

Preferred Pharmacy: _____ Phone: _____

Surgeries:

Surgery:	Year:	Surgery:	Year:

Immunizations: List the most recent date received.

Flu shot	Date:	MMR (measles, mumps, rubella)	Date:
Pneumonia shot	Date:	Tdap (Tetanus & pertussis)	Date:
Hepatitis A	Date:	Meningococcus	Date:
Hepatitis B	Date:	Chickenpox	Date:
Tetanus shot	Date:	Zostavax (Shingles)	Date
Gardasil / HPV	Date	Other:	Date:

Current condition: Please check all appropriate boxes.

CONSTITUTION	Yes	No	GI	Yes	No	NEUROLOGIC	Yes	No
Tired / weak			Blood in stool			Headache		
Fever / Chills			Nausea / vomiting			Seizures		
Appetite Changes			Abdominal pain			Numbness		
Weight Changes			constipation			Tingling / burning		
Jaundice			diarrhea					
EYES			Heartburn			**ENDOCRINOLOGIC**		
New eye pain			**GU**			Hair loss		
Blurred vision			Blood in urine			Tremors		
Discharge from eyes			Urine urgency			Thirsty		
glasses/contacts			Urinary frequency			Neck pain		
Vision changes			Painful urination					
ENT / MOUTH			discharge			**HEME/LYMPH**		
Sore throat			Urinary incontinence			Bleeding gums		
Jaw pain			**MUSCULOSKE**			Unusual		

			TAL			bruising		
Nose bleeds			Muscle pain			Swollen lymph nodes		
Ringing in ears			Joint swelling					
RESPIRATORY			Arthritis			**ALLERGY/IMMUNOLOGY**		
Shortness breath			Recent trauma			Nasal congestion		
Cough			Numbness			Runny nose		
Wheezing			Joint stiffness			Seasonal allergies		
Blood in Sputum								
Phlegm			**SKIN**			**PSYCHOLOGIC**		
Sleep apnea			New skin lesions			Agitation		
CARDIOVASCULAR			Rash			Hallucinations		
Chest pain			Wounds			Sleep problems		
Ankles swelling			Change in mole			Depression		
Palpations			Dry Skin					
fainting			Eczema					
sweating								
Fast/slow heartbeat								

Obstetric / Gynecological: (Women Only)

Last PAP smear Date: _____ Normal - Abnormal	Date of last Period: _____ Age of Menopause: _____	Number of pregnancies: _____ Number of Births: _____
Last Mammogram Date: _____ Normal - Abnormal	Cesarean section if yes Number: _____	Number of miscarriages: _____ Number of abortions: _____
Wake in the middle of night to go to the bathroom: Yes / No	Vaginal itching, burning, or discharge: Yes / No	Breast Lump or nipple discharge: Yes / No
Bleeding between periods: Yes / No	Age of first period:	Painful intercourse: Yes / No
Heavy periods: Yes / No	Hot flashes: Yes / No	Extreme menstrual pain: Yes / No

<u>Family History:</u> Please check all the appropriate boxes.

NEUROLOGICAL	**You**	**Father**	**Mother**	**Grandfather**	**Grandmother**	**Brother**	**Sister**
Alzheimer's							
Seizures							
Stroke							
Epilepsy							
Parkinson's							
ADHD							
RESPIRATORY	**You**	**Father**	**Mother**	**Grandfather**	**Grandmother**	**Brother**	**Sister**
Asthma							
COPD							
Tuberculosis							
CARDIOVASCULAR	**You**	**Father**	**Mother**	**Grandfather**	**Grandmother**	**Brother**	**Sister**
Heart attack							
Congestive heart failure							
Coronary artery disease							
High Blood Pressure							
Heart Murmur							
GENTOURINARY	**You**	**Father**	**Mother**	**Grandfather**	**Grandmother**	**Brother**	**Sister**
Kidney Stones							
Kidney disease							
GASTRO-INTESTINAL	**You**	**Father**	**Mother**	**Grandfather**	**Grandmother**	**Brother**	**Sister**
Hemorrhoids							
Peptic Ulcer disease							
Chron's disease							
Diverticulitis							
HEMATOLOGY	**You**	**Father**	**Mother**	**Grandfather**	**Grandmother**	**Brother**	**Sister**
Anemia							
Gout							
Sickle cell							
Lupus							
Osteoarthritis							
Cancer – **List type**							
Blood clots							
AIDS / HIV							
ENDOCRINE	**You**	**Father**	**Mother**	**Grandfather**	**Grandmother**	**Brother**	**Sister**

Diabetes Type 1							
Diabetes Type 2							
Thyroid							
Endometriosis							
PSYCHIATRIC	**You**	**Father**	**Mother**	**Grandfather**	**Grandmother**	**Brother**	**Sister**
Anxiety							
Depression							
Bi-polar							
If relative is deceased please list year of death	xxxxx xxxxx						

Social History: Pleas check / circle appropriate boxes

Issue:	**Yes**	**No**	**Issue**	**Yes**	**No**
Able to care of self			Sexually active		
Live alone or with others:	XXX	XXX	Protected sex: If so how often Always / Sometimes / Never		
Advanced Directives (Type:)			Smoking Statue: Never Former smoker / current smoker		
Education level – List grade: _____ School Name: _____	XXX	XXX	Smoker: if so how much: ½ PPD / 1 PPD/2 PPD / 2+PPD /1PPW/2PPW	XXX	XXX
Are you currently employed: Occupation: _____			Has smoked since age of : _____	XXX	XXX
General stress level: Low / Medium / High	XXX	XXX	Stopped smoking at age: _____ or year: _____	XXX	XXX
Number of children: _____	XXX	XXX	Passive smoke exposure		
Guns present in home:			Chewing tobacco: 1 / day 2-4 / day 5+ / day		
Alcohol intake: if so how often Occasional / Moderate / Heavy			Tobacco Years: _____	XXX	XXX
Caffeine intake: if so how often			Willingness to quit tobacco		

Occasional / Moderate / Heavy					
Illicit drugs: If so type:			Patient has tried smoking cessation aids, Type: _____		
Exercise level: if so how often? Occasional / Moderate / Heavy			Seat belt used routinely:		
Hard of hearing or deaf in one or both ears:			Sunscreen used routinely:		
Legally blind in one or both eyes:			Can you swim:		
Smoke alarm in home:			Can Child swim:		

Please add any other information about your health that you would like your provider to know here:

_____ _____

Parent, Guardian, or caregiver Date