

## History and Physical

Name \_\_\_\_\_ Date of Visit \_\_\_\_\_ Date of Birth \_\_\_\_\_

Referring Doctor/NP/PA \_\_\_\_\_ Pharmacy \_\_\_\_\_

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:**

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

**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			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	
Heart Disease			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	
High Blood Pressure			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	
Stroke			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	
Colon Cancer			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	
Colon Polyps			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	
Other Cancers (state type)			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	
Diabetes			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	
Stomach Ulcer			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	
Kidney Disease			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> 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

Pneumoccal  
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 ( )

