

HISTORY & PHYSICAL

Today's Date: _____

Name: (First) _____ (MI) ____ (Last) _____
 Date of Birth: ____/____/_____
 Primary Concern / Procedure: _____

Primary Care Prov./Phone Number: _____ Referred By: _____

Allergies:

Drug: _____ Reaction(s): _____

Latex Allergy: (Y) ____ (N) ____ Height: _____ Weight: _____

Environmental: _____

Medical History / Review of Systems:

Patient denies all of the following:

Have you ever had the following?
 (Please circle ANY that apply)

Have you recently had?
 (Please circle ANY that apply)

- | | |
|--|--|
| <input type="checkbox"/> Heart Disease / Heart Murmur | <input type="checkbox"/> Fever, chills, nausea, vomiting, diarrhea |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Weight increase, decrease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin rashes, lumps |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Frequent colds, sinus congestion |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Changes in vision, hearing |
| <input type="checkbox"/> Hepatitis / HIV | <input type="checkbox"/> Sore throat, bleeding gums |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Lumps in neck |
| <input type="checkbox"/> Herpes (cold sore, genital or shingles) | <input type="checkbox"/> Breast masses, nipple discharge |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chest pain, shortness of breath |
| <input type="checkbox"/> Acid Reflux Disease | <input type="checkbox"/> difficulty breathing |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heartburn, abdominal pain |
| <input type="checkbox"/> Sleep Apnea / Snoring | <input type="checkbox"/> Numbness/tingling/cramping in hands or feet |
| <input type="checkbox"/> Migraines / Headaches | <input type="checkbox"/> Swelling of hands or feet |
| <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Seizures, paralysis |
| <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Anxiety, depression |
| <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Cancer (of _____) | |

Number of Pregnancies: _____ Births: _____

Recent Mammogram Date: _____ Recent EKG Date: _____

Previous Surgeries / Hospitalizations and Date:

Current Medication(s):

Family Medical History: _____

Social History:

Use of tobacco:

- I am a non-smoker who has never used tobacco products.
 I am a former smoker who quit _____ months/years ago.
 I am a current smoker and I smoke _____ cigarettes/packs per day.

Use of alcohol:

- I never use alcohol.
 I occasionally use alcohol. Approximately _____ drink(s) per week.
 I am a regular user of alcohol. Approximately _____ drink(s) per day.

Use of drugs:

- I never use drugs.
 I only use doctor prescribed medications.
 I use drugs recreationally. Please list: _____

Exercise regime: _____

Type of employment: _____

I hereby declare that the information I have provided on this form is a true and accurate record to the best of my knowledge.

Patient Signature

Date

The following line is to be signed by a witness.

Reviewed by

Date