HISTORY & PHYSICAL

NAME: _____ DATE OF BIRTH:_____

FAMILY HISTORY	*If any blood relative has suffered any of the following – please circle the number & indicate which relative*

1) EPILEPSY 6) THYROID 11) OSTEOPOROSIS 16) ALCOHOLISM
2) MIGRAINE 7) HAYFEVER 12) ARTHRITIS 17) CANCER
3) MENTAL ILL 8) ASTHMA 13) HEART DISEASE
4) GLAUCOMA 9) ANEMIA 14) STROKE
5) DIABETES 10) BLEEDS EASILY 15) HYPERTENSION

_____
_____
_____

YEAR	SURGERY	YEAR	SURGERY

LIST ALL MEDICATIONS YOU ARE NOW TAKING			ALLERGIES

MEDICAL HISTORY Check all that apply

☐	Decreased Hearing	☐	Loss of Appetite	☐	Cancer	☐	Chicken pox ___Polio ___ Mumps
☐	Ringing in Ear	☐	Difficulty swallowing	☐	Diabetes	☐	Measles ___ German Measles
☐	Ear Infections-frequent	☐	Indigestion/Heartburn	☐	Thyroid Disease	☐	Rheumatic fever ___ Scarlet
☐	Dizzy spells	☐	Persistent Nausea/vomiting	☐	Convulsions/seizures	☐	Tuberculosis ____ Herpes
☐	Failing vision __ Eye pain	☐	Peptic ulcers	☐	Stroke	☐	Contact w/bloody or body fluids
☐	Double or blurred vision	☐	Abdominal Pain – chronic	☐	Tremor/Hands shaking	☐	
☐	Eye infections – frequent	☐	Gall bladder trouble	☐	Muscle weakness	☐	Alcohol _____oz. Per week
☐	Nose bleeds – recurrent	☐	Jaundice / hepatitis	☐	Numbness/tingling	☐	Smoking ___cig per day___#yrs
☐	Sinus trouble	☐	Change in Bowel Habits	☐	Headaches – frequent	☐	Coffee/tea ____ cups per day
☐	Sore throats – frequent	☐	Diarrhea ___ constipation	☐	Arthritis/Rheumatism	☐	FEMALES – Please complete
☐	Hayfever / allergies	☐	Diverticulitis ___ Crohns	☐	Back Pain – recurrent	☐	Menstrual Flow:
☐	Hoarseness - prolonged	☐	Bloody / tarry stools	☐	Bone fracture/joint inj	☐	__Reg ___Irreg ____pain/cramp
☐	Pneumonia / Pleurisy	☐	Hemorrhoids	☐	Gout ___Osteoporosis	☐	__Days of flow ___ Lgth cycle
☐	Bronchitis / Chronic cough	☐	Hernia	☐	Foot pain ___ cold numb feet	☐	Date 1st day of last period ____
☐	Asthma / Wheezing	☐	Urine Infections – freq	☐	Rashes ___Hives	☐	___pain/bleeding during/after sex
☐	Shortness of breath	☐	Blood in Urine	☐	Psoriasis ___ Eczema	☐	Number of:
☐	On exertion ___ Lying flat	☐	Urination __ overnite > 2	☐	Sleeping – difficulty	☐	___ Pregnancies ___ Abortions
☐	Chest pain	☐	__Painful __ loss of control	☐	Nervousness	☐	___Miscarriages ___ Live births
☐	High Blood pressure	☐	__Decrease in force/flow	☐	Depression	☐	Birth Control Method _____
☐	Heart Murmur	☐	Kidney Stones	☐	Memory Loss	☐	B.C. Pill (name) _____
☐	Irr Pulse ___Palpitations	☐	Venereal Disease	☐	Moodiness – excessive	☐	Flushing / Menopause
☐	Swollen Ankles	☐	Urethral Discharge	☐	Phobias	☐	Date of last PAP test
☐	Fainting Spells	☐	Chronic fatigue	☐	Mental Illness	☐	___Normal ___ Abnormal
☐	Leg Pain – walking	☐	Weight loss – recent	☐	_____	☐	Date of last mammogram
☐	Varicose veins / Phlebitis	☐	Anemia ___ Bruise easily	☐	_____	☐	___Normal ___ Abnormal

SYNOPSIS

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_____
_____
_____
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