****

**HISTORY & PHYSICAL**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** | | | | **Date of Birth** | **Today’s Date** Page 1 | |
| **MEDICAL HISTORY: Do you have a history of any of the following?** | | | | | | |
|  | Hypertension (High Blood Pressure) |  | Diabetes | |  | Stroke |
|  | Heart Attack |  | Thyroid Disease | |  | Emphysema/COPD |
|  | Glaucoma |  | Kidney Disease | |  | Ulcers |
|  | Coronary Artery Disease /Heart Failure |  | Vascular Disease | |  | Asthma |
|  | Cancer, If yes, list type | | | | | |
|  | Other, list | | | | | |
| **REVIEW OF SYMPTOMS: Please check if you have any of the following** | | | | | | |
| **CONSTITUTIONAL** | | **EYES** | | | **EARS, NOSE & THROAT** | |
|  | Chills |  | Diminished Visual Acuity | |  | Nasal Discharge |
|  | Fatigue |  | Discharge | |  | Nasal Congestion |
|  | Fever |  | Dry Eye | |  | Hoarseness |
|  | Feeling Poorly |  | Eye Pain | |  | Decreased Hearing |
|  | Weight Gain |  | Red Eye | |  | Ear Pain |
|  | How much gain? |  |  | |  | Nosebleed |
|  | Weight Loss |  |  | |  | Sore Throat |
|  | How much loss? |  |  | |  |  |
| **CARDIAC** | | **RESPIRATORY** | | | **GASTROINTESTINAL** | |
|  | Heart Rate Too Fast |  | Cough | |  | Black or Tarry Stool |
|  | Heart Rate Too Slow |  | Shortness of Breath | |  | Abdominal Pain |
|  | Leg Claudication |  | Shortness of Breath at Rest | |  | Blood in Stool |
|  | Leg Edema |  | Shortness of Breath w/Exertion | |  | Constipation |
|  | Chest Pain |  | Wheezing | |  | Diarrhea |
|  | Palpitations |  |  | |  | Heartburn |
|  |  |  |  | |  | Vomiting |
| **GENITOURINARY** | | **MUSCULOSKELETAL** | | | **NEUROLOGIC** | |
|  | Incontinence |  | Joint and Muscle Aches | |  | Confusion |
|  | Pelvic Pain |  | Back Pain | |  | Limb Weakness |
|  | Menstrual Problems |  | Limb Pain | |  | Difficulty Walking |
|  | Frequent Urination at Night |  | Limb Swelling | |  | Dizziness |
|  | Vaginal Discharge |  | Joint Stiffness | |  | Fainting |
|  | Abnormal Vaginal Bleeding |  | Swollen Joints | |  | Headache |
|  | Frequent Urination |  |  | |  |  |
|  | Painful Urination |  |  | |  |  |
| **PSYCHIATRIC** | | **SKIN** | | | **HEMATOLOGY** | |
|  | Sleep Changes |  | Skin Wounds | |  | Easy Bleeding |
|  | Change of Personality |  | Change of a Mole | |  | Swollen Neck Glands |
|  | Emotional Problems |  | Breast Pain | |  | Easy Bruising |
|  | Anxiety |  | Breast Lump | |  | Swollen Glands |
|  | Depressed Mood |  | Itching | |  |  |
|  | Suicidal Thoughts |  | Skin Lesion(s) | |  |  |
| **ENDOCRINE/HORMONE** | |  |  | |  |  |
|  | Muscle Weakness |  |  | |  |  |
|  | Eyeball Protrusion |  |  | |  |  |
|  | Deepening of Voice |  |  | |  |  |
|  | Hot Flashes |  |  | |  |  |
|  | Weakness |  |  | |  |  |

****

**HISTORY & PHYSICAL**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | | | | | | | | | | | | | **Date of Birth** | | | | | | | | **Today’s Date** Page 2 | | | | | |
| **WOMEN:** Have you had a recent mammogram? | | | | | | | | | | | | | | | |  | | Yes |  | No | | | | | | |
| **If yes,** When? Where? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **OTHER HEALTH ISSUES:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **FAMILY HISTORY:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Adopted |  | Do not know maternal family history | | | | | | | | | | | |  | | Do not know paternal family history | | | | | | | | | |
| Please include any cancer, cardiac disease, diabetes, hypertension, stroke and endocrine/hormonal problems. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Relationship** | | **Status** | | | | | | **Maternal/**  **Paternal** | | | | | | | **Disease (If Cancer list type)** | | | | | | | | | | **Age of Onset of any Cancer** | |
| Mother | |  | Alive |  | Deceased | | |  | | | | | | |  | | | | | | | | | |  | |
| Father | |  | Alive |  | Deceased | | |  | | | | | | |  | | | | | | | | | |  | |
| Brother | |  | Alive |  | Deceased | | |  | | | | | | |  | | | | | | | | | |  | |
| Sister | |  | Alive |  | Deceased | | |  | | | | | | |  | | | | | | | | | |  | |
|  | |  | Alive |  | Deceased | | |  | | | | | | |  | | | | | | | | | |  | |
|  | |  | Alive |  | Deceased | | |  | | | | | | |  | | | | | | | | | |  | |
|  | |  | Alive |  | Deceased | | |  | | | | | | |  | | | | | | | | | |  | |
| **SOCIAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you smoke? | | | | | |  | Yes | | |  | No | How much? How many years? | | | | | | | | | | | | | | |
| Former smoker? | | | | | |  | Yes | | |  | No |  | | Never | | | | | | | | | | | | |
| Do you drink alcohol? | | | | | |  | Yes | | |  | No | How much? | | | | | | | | | | | | | | |
| Do you take herbal supplements? | | | | | |  | Yes | | |  | No | If Yes, list on Page 3 under medications. | | | | | | | | | | | | | | |
| Do you use illegal drugs? | | | | | |  | Yes | | |  | No | How much? | | | | | | | | | | | | | | |
| What type of job do you have? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is the condition work related? | | | | | |  | Yes | | |  | No | Will this be Worker’s Comp? | | | | | | | | | |  | Yes |  | | No |
| Date of Injury? / / How did the injury happen? | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PAST SURGICAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you had surgery before? | | | | | |  | Yes | | |  | No | If yes, please list procedure, date, surgeon and hospital. | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Colonoscopy | | | |  | Yes |  | No | | If yes, when? / / Surgeon: | | | | | | | | | | | | | | | | | |
| EDG (Stomach Scope) | | | |  | Yes |  | No | | If yes, when? / / Surgeon: | | | | | | | | | | | | | | | | | |
| Heart Stents | | | |  | Yes |  | No | | If yes, when? / / | | | | | | | | | | | | | | | | | |
| Name of Cardiologist | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Pacemaker/Defibrillator | | | | | |  | Yes | | |  | No | If yes, what brand? | | | | | | | | | | | | | | |
| **ALLERGIES** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergies to Medications | | | | | |  | Yes | | |  | No | If yes, please list medication and type of reaction: | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergic to Latex Products | | | | | |  | Yes | | |  | No |  | | | | | | | | | | | | | | |

****

**HISTORY & PHYSICAL**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** | | | **Date of Birth** | | **Today’s Date** Page 3 | |
| **MEDICATIONS** | | | | | | |
| List all prescription and non-prescription medications you take, including dosage and frequency. Insulin, inhalers, patches, birth control pills, herbal supplements, aspirin and any other blood thinner should be included here: | | | | | | |
| **Name of Medication** | **Dosage** | **Frequency** | | **Reason for Taking** | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
|  |  |  | |  | | |
| **To the best of my knowledge, the information provided is complete and correct. I understand that it is my responsibility to inform my doctor if I (or my child) have a change in health.** | | | | | | |
| **Signature of Patient, Guardian or Personal Representative** | | | | | | **Date** |