****

**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** |