

History & Physical

Patient Name _____ DOB _____ Date _____

Past Medical History:

Do you have any of the following medical conditions/ diseases?

Liver	Heart	Lung	Diabetes	Blood Clots
Kidney	Cancer	High Blood Pressure	Arthritis	Seizures
Asthma	Hepatitis	Bleeding Tendencies	Stroke	Sleep Apnea
Tuberculosis	Gout	Low Blood Pressure	Thyroid	Colitis
Other, Explain: _____				

When was your last tetanus shot? _____

Please list **all** previous surgeries including date performed and performing physician if known:

Family Medical History:

Do any of your immediate family members have any of the following medical conditions/ diseases?

High Blood Pressure	Low Blood Pressure	Strokes	Heart Disease
Arthritis/ Gout	Parkinson's Disease	Epilepsy	Tuberculosis
Alcoholism	Lung Disease	Diabetes	Kidney Disease
Nervous Breakdown	Bleeding Tendency	Heart Attack	Cancer (type)
Other, Explain _____			

If Alive:

Father: Age _____ Health: Good Fair Poor

Mother: Age _____ Health: Good Fair Poor

If Deceased:

Age: _____ Cause: _____

Age: _____ Cause: _____

Social History:

Highest Level of Education: _____

Employed: Yes No If yes, where? _____

Have you ever lived outside the United States? Yes No If yes, where? _____

Have you served in the military? Yes No If yes, rank and type of discharge? _____

Are you a smoker? Yes No How much alcohol do you consume? _____

Please circle if you have any of the following:

Eye:

Redness/ Discharge
Glasses/ Contacts
Blurred/ Double Vision
Cataracts
Glaucoma
Other: _____

Ears/ Nose/ Throat:

Sore Throat
Nosebleed
Runny Nose
Hoarse
Hearing Loss
Other: _____

Cardiovascular:

Chest Pain
Heart Murmur
Lower Leg Swelling
Irregular Heart Rate
High Blood Pressure
Other: _____

Respiratory:

Shortness of Breath
Cough
Asthma
Coughing up Blood
Hay Fever with Wheezing
Post Nasal Drip
Other: _____

Gastrointestinal:

Diarrhea
Abdominal Pain
Gallstones
Ulcers
Jaundice
Bloody Stools
Other: _____

Genitourinary:

Burning/ Painful Urination
Vaginal/ Penile Discharge
Urinary Frequency
Unable to Control Urine
Blood in Urine
Other: _____

Musculoskeletal:

Pain in Muscle
Neck/ Back Pain
Joint Pain/ Swelling
Arm/ Leg inflammation
Difficulty Moving Limbs
Other: _____

Skin/ Breast:

Rash
Lesions
Skin Cancers
Eczema
Masses
Other: _____

Neurological:

Headache
Numbness/ Weakness
Seizures
Paralysis
Other: _____

Endocrine:

Fatigue
Increase in Hair growth/ loss
Heat Intolerance
Increased Thirst
Other: _____

Psychiatric:

Change in Mental Status
Confusion
Depression
Agitation
Other: _____

Hematologic/ Lymphatic

Bleeding Tendency
Lymph Node Enlargement or pain
Anemia
Other: _____

Allergy/ Immunology

Runny Nose
Skin- Itching/ rash
Asthma
Sneezing
Other: _____