

HISTORY AND PHYSICAL

DATE _____

NAME _____ SEX MALE _____ FEMALE _____ BIRTHDATE _____

NAME OF PHYSICIAN THAT REFERRED YOU _____

CURRENT CONDITION: _____

ASSOCIATED SYMPTOMS: _____

WHAT MEDICAL PROBLEMS HAVE YOU HAD IN THE PAST, OTHER THAN WHAT YOU ARE SEEING THE DOCTOR TODAY? THESE MAY BE NEITHER ACTIVE OR BOTHERING YOU NOW; SOME EXAMPLES: CANCER, COLON PROBLEMS, PNEUMONIA, BRONCHITIS, DEPRESSION, MIGRAINES, ETC; _____

PAST SURGICAL HISTORY: _____

ARE YOU TAKING ANY MEDICATIONS NOW? YES _____ NO _____ IF YES, PLEASE LIST THEM: _____

DO YOU HAVE ANY ALLERGIES? YES _____ NO _____ IF YES, PLEASE LIST THEM: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SOCIAL AND FAMILY HISTORY:

DO YOU SMOKE? YES _____ NO _____ HOW MANY PACKS A DAY? _____
DO YOU DRINK? YES _____ NO _____ HOW MUCH OR HOW FREQUENT? _____

HAS ANYONE IN YOUR FAMILY(MOTHER, FATHER, BROTHERS, SISTERS, GRANDMOTHERS, GRANDFATHERS) EVER HAD ANY OF THE FOLLOWING CONDITIONS? PUT A CHECK NEXT TO EACH.

HIGH BLOOD PRESSURE _____

DIABETES _____

HEART PROBLEMS _____

CANCER _____

HAVE YOU PERSONALLY HAD OR ARE EXPERIENCING NOW, ANY OF THE FOLLOWING CONDITIONS?

HIGH BLOOD PRESSURE _____

HEPATITIS _____

DIABETES _____

ULCER DISEASE _____

HEART PROBLEMS _____

VASCULAR DISEASE _____

CANCER _____

BLOOD CLOTS _____

HIV _____