

History & Physical

(To Be Completed by Patient)

NAME _____ D.O.B. _____

REASON FOR VISIT _____

ALLERGIES TO MEDICATIONS:

TYPE OF REACTION:

PLEASE DESCRIBE ANY PREVIOUS SURGERIES (With approximate dates):

LIST ALL SERIOUS ILLNESSES (And any medical diagnosis given in the past i.e. Diabetes, Angina, etc.)

LIST CURRENT MEDICATIONS (Include over the counter and birth control):

SOCIAL HISTORY: If there is no change since your last exam, check here _____

Married _____ Divorced _____ Separated _____ Widowed _____ Single _____

Occupation _____ Retired _____

Hobbies/Interests _____

Travel Outside the United States _____ Where _____

Exposure to environmental agents? _____

DO YOU:

Exercise regularly? Yes _____ No _____ Type _____ Times /Week _____

Smoke? No _____ Yes _____ Packs per day _____ for # of years _____ Year you quit _____

Drink Alcohol? No _____ Drinks per week _____ Type: (Wine/Beer/Liquor) _____

If no, did you ever drink in the past? _____ Amount _____, How many years did you drink _____

Year you quit _____

Take in Caffeine? No _____ Yes _____ Cups per day _____

Use of recreational drugs? No _____ Yes _____

IMMUNIZATIONS: Please list year of last shot given.

Pneumonia _____ Tetanus _____ Adacel _____ Flu _____ Hepatitis B _____ Hepatitis A _____

Zostavax _____ Last skin test for TB _____ Normal/Abnormal _____

Do you have a living will? No _____ Yes _____ If yes, please provide us with a copy for our records.

FAMILY HISTORY: Please list any illnesses or deaths in the family. If no change since last visit with us, check here _____

	AGE	ALIVE	HEALTH PROBLEMS
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
BROTHER(S)	_____	_____	_____
	_____	_____	_____
SISTER(S)	_____	_____	_____
	_____	_____	_____
CHILDREN	_____	_____	_____
	_____	_____	_____
GRANDFATHERS	_____	_____	_____
	_____	_____	_____
GRANDMOTHERS	_____	_____	_____
	_____	_____	_____

PLEASE LIST THE LAST TIME YOU HAD:

a) An eye exam month _____/year _____ Normal _____ Abnormal _____

b) For females 1) Pap/pelvic exam month _____/year _____ Normal _____ Abnormal _____

2) Breast exam month _____/year _____ Normal _____ Abnormal _____

3) Mammogram month _____/year _____ Normal _____ Abnormal _____

c) Date of last medical exam _____ Date of last lab test _____

Use of alternative Doctors or medical therapies: _____

Are there any other items you are concerned about or want to discuss with the doctor?

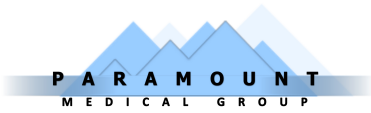
Below please list any test or procedures done since your last physical exam, ie: Colonoscopy, CT Scans Sonograms, Kidney/Intestinal X-Rays or procedures, Stress Test etc. with approximate dates, reason for test (if known to you) and the Doctor who ordered the test in case more information is needed.

	<u>Procedure or Test Done</u>	<u>Approx. Date of Testing</u>	<u>Reason for Test</u>	<u>Result of Test</u>	<u>Ordering Doctor</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

(Patient Signature)

(Date)

*If there is anything you feel uncomfortable reporting on these forms, please feel free to discuss it in private with your Physician. Thank you for taking the time and assisting us with your health care.



Patient Name: _____ Patient DOB: _____

Patient Medical History & Review of Systems

Please indicate any personal history below, past or present

Where do you currently reside? Independently In an Assisted Living Facility In a Nursing Home

Constitutional Systems

- Recent weight changes No Yes
loss / gain # of pounds _____
- Fever No Yes
- Eye disease or cataracts No Yes
- Wear glasses/contact lenses No Yes
- Blurred or double vision No Yes
- Glaucoma No Yes

Ears/Nose/Mouth/Throat

- Hearing loss or ringing No Yes
- Chronic sinus problems No Yes
- Nose bleeds No Yes
- Sore throat or voice change No Yes

Cardiovascular

- Heart murmur No Yes
- Mitral valve prolapse No Yes
- Rheumatic fever No Yes
- High or low blood pressure medication No Yes
- Chest pain or angina pectoris in last 30 days No Yes
- Palpitation No Yes
- Congestive Heart Failure No Yes
- Irregular pulse No Yes
- History of heart attack When? _____ No Yes
- Feet, ankle, or hand swelling No Yes
- Heart disease No Yes
- Coronary angiogram When? _____ No Yes
- Heart surgery When? _____ No Yes
- Peripheral Vascular Disease No Yes

Respiratory

- Chronic or frequent coughs No Yes
- Emphysema or COPD No Yes
- Asthma No Yes
- Bronchitis No Yes
- Tuberculosis or positive TB skin test No Yes
- Shortness of breath while walking or lying flat No Yes
- Wheezing No Yes
- Pneumonia No Yes
- Spitting up blood No Yes
- Sleep apnea No Yes

Gastrointestinal

- Abdominal pain No Yes
- Esophageal varices No Yes
- Nausea or vomiting No Yes
- Frequent diarrhea No Yes
- Change in bowel movement No Yes
- Painful bowel movements or constipation No Yes
- Rectal bleeding or blood in stool No Yes
- Stomach ulcer No Yes
- Vomiting blood No Yes
- History of liver disease No Yes
- Jaundice No Yes
- Hepatitis No Yes
- Ascites No Yes
- Hemorrhoids No Yes

Genitourinary

- Frequent urination No Yes
- Burning or painful urination No Yes
- Blood in urine No Yes
- Change in force of stream when urinating No Yes
- Incontinence or dribbling No Yes
- Kidney stones No Yes
- Male – testicle pain No Yes
- Date of last PSA _____
- Date of LMP _____
- Hysterectomy or Tubal ligation No Yes

Musculoskeletal

- Joint pain No Yes
- Muscle or joint weakness No Yes
- Muscle pain or cramps No Yes
- Back pain No Yes
- Cold extremities No Yes
- How far can you walk without pain? _____
- Pain while at rest No Yes
- Arthritis No Yes
- Hernia No Yes

Integumentary (skin, breast)

- Rash or itching No Yes
- Change in skin color No Yes
- Varicose veins No Yes
- Breast pain No Yes
- Breast lump No Yes
- Breast discharge No Yes
- Date of last mammogram _____

Psychiatric

- Memory loss or confusion No Yes
- Nervousness No Yes
- Depression No Yes
- Insomnia No Yes

Neurological

- Frequent/recurring headaches No Yes
- Light headed or dizzy No Yes
- Convulsions or seizures No Yes
- Numbness/tingling sensation No Yes
- Tremors No Yes
- Paralysis No Yes
- Head injury No Yes
- Stroke (RIND or TIA) No Yes
- Migraine headaches No Yes
- Brain tumor No Yes

Endocrine

- Prescription steroid use No Yes
- Glandular/hormone problems No Yes
- Excessive thirst or urination No Yes
- Heat or cold intolerance No Yes
- Diabetes No Yes
oral medications or insulin
- Thyroid disease No Yes
- Kidney disease No Yes
- Kidney failure No Yes
- Hemo Dialysis or CAPD No Yes

Hematologic/Lymphatic

- Slow to heal after cuts No Yes
- Tendency to bleed or bruise No Yes
- Anemia No Yes
- Phlebitis or blood clots in legs No Yes
- Blood or plasma transfusion No Yes
- Enlarged glands No Yes
- Cancer No Yes
- Chemo or Radiation No Yes
- HIV + No Yes

Date & location of most recent bloodwork

Date & location of most recent EKG

Date & location of most recent chest X-ray

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need and release information to others if necessary for my care.

Signature of patient (or parent if minor) _____

Date _____