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History & Physical

Name: _____ SS # _____ Date : _____
Phone (Home) : _____ Work : _____ Previous PCP: _____
Date of Birth: _____ Age: _____ Referred by: _____
Chief Complaint _____

DRUG ALLERGIES:

_____
_____
_____

HOSPITALIZATION OR SURGERY

FAMILY HISTORY

| | Father | Mother | Father's Parents | Mother's Parents | Siblings | children |
|---|---|---|---|---|---|---|
| Heart Diseases | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Epilepsy/ Convulsions | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bleeding Disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other:_____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| Reason | Date | Reason | Date |
|---|---|---|---|
| | | | |
| | | | |

MEDICAL HISTORY

☐ Headache _____
☐ Shortness of breath _____
☐ Heart Palpitations _____
☐ Heart Murmur _____
☐ Chest Pain _____
☐ Dizziness/ Fainting _____
☐ Peripheral Vascular Disease _____
☐ Allergies _____
☐ Asthma _____
☐ Bronchitis _____
☐ Pneumonia _____
☐ Ulcer _____
☐ GI Disorder _____

☐ Lactose Intolerant _____
☐ Gallbladder disease _____
☐ Prostate Disease _____
☐ Bowel Irregularity _____
☐ Incontinence _____
☐ Sexual/ menstrual dysfunctions _____
☐ Venereal Disease _____
☐ Frequent Diseases _____
☐ Hepatitis _____
☐ Anemia _____
☐ Arthritis: _____
☐ Osteoporosis _____
☐ Nervousness _____

☐ Depression _____
☐ Gout _____
☐ Scarlet fever _____
☐ Chronic Rashes _____
☐ Rheumatic fever _____
☐ Varicella _____
☐ Mumps _____
☐ Measles _____
☐ Rubella _____
☐ Diphtheria _____
☐ Tetanus _____
☐ Other _____
☐ Other _____

Women only: Pregnant? ☐ YES ☐ NO Planning pregnancy? ☐ YES ☐ NO
Last Pap Smear: _____ Mammogram: _____

Men Only: It's common for men to occasionally experience erection difficulties. Is this something that happens to you? YES NO
How often does this occur? ☐ Frecuently ☐ Sometimes ☐ Rarely

HABITS

Smoke: Packs daily :_____ How long ?_____ Interested in stoppingr?_____
Cofee: Cups Daily: _____ Other Caffeine:_____
Sleep: Difficulty falling asleep _____ Continuity disturbances _____ Snoring: _____ Early Morning awakening _____ Daytime Drowsiness _____ Other :_____

Exercise Routine: _____
Alcohol: Type: _____ Amount: _____

Other Studies: Colonoscopy _____ Bone Density _____
Diet: Salt Intake : _____ Fat Intake : _____

Are you under care of any other physicians? Please Specify:

_____

_____

_____