

## HISTORY AND PHYSICAL

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**CHIEF COMPLAINT:** What brought you to the doctor today?

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Describe pain: \_\_\_\_\_ Severity of pain on scale 1-10 \_\_\_\_\_

How long has this been present: \_\_\_\_\_

**PAST MEDICAL HISTORY:** Do you have a history of any of the following?

- |  |   |                                      |  |                                       |                                 |
|--|---|--------------------------------------|--|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Hypertension              | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Stroke      | <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Tumors       | <input type="checkbox"/> DVT    |
| <input type="checkbox"/> Heart/Circulation Trouble | <input type="checkbox"/> Hypoglycemia   | <input type="checkbox"/> Emphysema   | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Gout   |
| <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers      | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Liver Disease             | <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Leg Cramps          | <input type="checkbox"/> Tuberculosis |                                 |
| <input type="checkbox"/> Thyroid Disease           | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Bleeding Tendencies |                                       |                                 |
| <input type="checkbox"/> Other _____               |   |                                      |  |                                       |                                 |
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General Health:  Good  Fair  Poor Height \_\_\_\_\_ Weight \_\_\_\_\_

**PAST SURGICAL HISTORY** Have you had any surgery before \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, please list procedure and date \_\_\_\_\_

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**ALLERGIES** Do you have any allergies to medications? \_\_\_\_\_ YES \_\_\_\_\_ NO

- |                                      |                                 |                                  |  |                                      |   |                                       |
|--------------------------------------|---------------------------------|----------------------------------|--|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Penicillin  | <input type="checkbox"/> Sulfa  | <input type="checkbox"/> Codeine | <input type="checkbox"/> Demerol       | <input type="checkbox"/> Aspirin     | <input type="checkbox"/> Novocain       | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Darvon      | <input type="checkbox"/> Cipro  | <input type="checkbox"/> Seconal | <input type="checkbox"/> Tetanus       | <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Eggs         |
| <input type="checkbox"/> Adhesives   | <input type="checkbox"/> Iodine | <input type="checkbox"/> Motrin  | <input type="checkbox"/> Nylon/Plastic |                                      |   |                                       |
| <input type="checkbox"/> Other _____ |                                 |                                  |  |                                      |   |                                       |

Are you allergic to latex products \_\_\_\_\_ YES \_\_\_\_\_ NO

**MEDICATIONS** List all prescription medications you take, include dosage and frequency. Insulin, inhaler and patches should be included here

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List all non-prescription medications you take routinely \_\_\_\_\_

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Name \_\_\_\_\_ Date \_\_\_\_\_

**Social History**

Do you smoke \_\_\_\_\_ Yes \_\_\_\_\_ No How Much Per Day \_\_\_\_\_ X \_\_\_\_\_ Years

Do you drink alcohol \_\_\_\_\_ Yes \_\_\_\_\_ No How Much \_\_\_\_\_

What type of job do you have \_\_\_\_\_

**Family History** Do any illnesses run in your family

Mother \_\_\_\_\_

Father \_\_\_\_\_

Siblings \_\_\_\_\_

**Review of Systems** Please check if you have any of the following

**CONSTITUTIONAL**

- \_\_\_\_\_ Fever
- \_\_\_\_\_ Weight loss
- \_\_\_\_\_ Lethargy

**EARS, NOSE, MOUTH & THROAT**

- \_\_\_\_\_ Tinnitus
- \_\_\_\_\_ Nose bleeds
- \_\_\_\_\_ Nasal congestion
- \_\_\_\_\_ Sore throat
- \_\_\_\_\_ Difficulty swallowing

**GENITOURINARY**

- \_\_\_\_\_ Frequency
- \_\_\_\_\_ Blood in urine
- \_\_\_\_\_ Abnormal urine color
- \_\_\_\_\_ Painful urination
- \_\_\_\_\_ Awaken to urinate
- \_\_\_\_\_ Unable to fully empty bladder
- \_\_\_\_\_ Incontinence

**HEMATOLOGIC/ LYMPHATIC**

- \_\_\_\_\_ Easy bruising
- \_\_\_\_\_ Anemia
- \_\_\_\_\_ Blood abnormalities
- \_\_\_\_\_ Blood thinners
- \_\_\_\_\_ Lymph node enlargement

**EYES**

- \_\_\_\_\_ Blurred vision
- \_\_\_\_\_ Cataracts
- \_\_\_\_\_ Glasses

**RESPIRATORY**

- \_\_\_\_\_ Chronic cough
- \_\_\_\_\_ Wheezing
- \_\_\_\_\_ Emphysema
- \_\_\_\_\_ Cough blood
- \_\_\_\_\_ Productive cough
- \_\_\_\_\_ Asthma

**MUSCULOSKELETAL**

- \_\_\_\_\_ Pain
- \_\_\_\_\_ Limited range of motion
- \_\_\_\_\_ Limited strength
- \_\_\_\_\_ Arthritis

**NEUROLOGICAL**

- \_\_\_\_\_ Headache
- \_\_\_\_\_ Fainting
- \_\_\_\_\_ Dizziness
- \_\_\_\_\_ Memory loss
- \_\_\_\_\_ Numbness

**CARDIOVASCULAR**

- \_\_\_\_\_ Shortness of breath
- \_\_\_\_\_ Chest pain (angina)
- \_\_\_\_\_ Heart palpitations
- \_\_\_\_\_ Heart attack
- \_\_\_\_\_ Stroke
- \_\_\_\_\_ Cold extremities
- \_\_\_\_\_ Hypertension

**GASTROINTESTINAL**

- \_\_\_\_\_ Pain
- \_\_\_\_\_ Diarrhea
- \_\_\_\_\_ Constipation
- \_\_\_\_\_ Blood in stool
- \_\_\_\_\_ Mucus in stool
- \_\_\_\_\_ Nausea
- \_\_\_\_\_ Vomiting
- \_\_\_\_\_ Vomit blood
- \_\_\_\_\_ Heartburn
- \_\_\_\_\_ Change in stool
- \_\_\_\_\_ Food intolerance
- \_\_\_\_\_ Loss of appetite

**INTEGUMENTARY**

- \_\_\_\_\_ Rash
- \_\_\_\_\_ Itching
- \_\_\_\_\_ Dry Skin

**ENDOCRINE**

- \_\_\_\_\_ Night sweats
- \_\_\_\_\_ Thyroid disease
- \_\_\_\_\_ Diabetes

Reviewed \_\_\_\_\_