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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:

_____

_____

_____