HISTORY & PHYSICAL

TODAY'S DATE: _____/_____/_____ **NAME:** _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____

PHONE: (H)_____ (C)_____ (W)_____ **OCCUPATION:** _____

SS#: _____/_____/_____ **DATE OF BIRTH:** _____/_____/_____ **MARITAL STATUS:** M S D W

CURRENT MEDICATIONS		DRUG ALLERGIES
1.	7.	1.
2.	8.	2.
3.	9.	3.
4.	10.	4.
5.	11.	5.
6.	12.	6.

HOSPITALIZATIONS OR SURGERIES			
DATE	REASON	DATE	REASON

MEDICAL HISTORY

	Ringing in ears		Jaundice/Hepatitis		Arthritis/Rheumatism		Females – *Please Complete*
	Ear Infections – *Frequent*		Change in Bowel Habits		Osteoporosis		Pregnant? Y N
	Dizziness/Fainting		___Diarrhea ___ Constipation		Back Pain - *Recurrent*		Planning Pregnancy? Y N
	Hair Loss		___Diverticulosis ___ Crohn's/Colitis		Bone Fracture/Joint Injury		Menstrual Flow:
	Failing Vision		Bloody or Tarry Stools		Gout		____Regular ____Irregular
	Eye Infections		Hemorrhoids		___Foot Pain ___Cold Numb Feet		____Cramps/Pain
	Nose Bleeds		Hernia		___Rashes ___Hives		____Days of Flow
	Sinus Trouble		Blood in Urine		___Psoriasis ___Eczema		____Length of Cycle
	Sore Throats - *Frequent*		Urination: ___ Overnight > twice		___Nervousness ___Depression		Date of 1st day of last period:_____
	Hayfever/Allergies		___ Painful ___ Loss of Control		Memory Loss		Pain/Bleeding during or after Sex
	Pneumonia		___ Decrease in Force/Flow		Moodiness - *Excessive*		Number of :
	Bronchitis/Chronic Cough		Kidney Stones		Phobias		_____Pregnancies
	Asthma/Wheezing		Veneral Disease		Mental Illness		_____Miscarriages
	Chest Pain		Urethral Discharge		Lactose Intolerance		_____Abortions
	High Blood Pressure		Chronic Fatigue		Prostate Disease		_____Live Births
	Heart Murmur		Weight Loss - *Recent*		Sexual/Menstrual Dysfunction		Birth Control Method:
	Swollen Ankles		___Anemia ___ Bruise Easily		Diphtheria		B.C. Pill (Name):
	Leg Pain - *Walking*		Cancer		Tetanus		Flushing/Menopause
	Varicose Veins/Phlebitis		Diabetes		____Chicken Pox ___Polio		Date of Last PAP test:
	Loss of Appetite		Thyroid Disease		____Mumps ___Measles		____Normal ____Abnormal
	Difficulty Swallowing		Convulsions/Seizures		____Rubella ___Rheumatic Fever		Date of Last Mammogram:
	Indigestion or Heartburn		Stroke		____Scarlet Fever ___Tuberculosis		____Normal ____Abnormal
	Persistent Nausea/Vomiting		Tremor/Hands Shaking		Herpes		
	Peptic Ulcers		Muscle Weakness		Other _____		
	Abdominal Pain - *Chronic*		Numbness/Tingling Sensations		Other _____		
	Gall Bladder Trouble		Headaches - *Frequent*				

FAMILY HISTORY

	Father	Mother	Child	Sibling	Father's Parents	Mother's Parents		Father	Mother	Child	Sibling	Father's Parents	Mother's Parents
ALCOHOLISM							HIGH BLOOD PRESSURE						
ASTHMA							KIDNEY DISEASE						
BLEEDING DISORDER							MENTAL ILLNESS						
CANCER							MIGRAINE						
DIABETES							OSTEOPOROSIS						
GLAUCOMA							STROKE						
EPILEPSY/CONVULSIONS							THYROID DISEASE						
HAIR LOSS							OTHER_____						
HEART DISEASE													

HABITS

ALCOHOL: TYPE_____ AMOUNT_____	SLEEP: DIFFICULTY FALLING ASLEEP _____	SMOKE: PACKS DAILY _____	COFFEE: CUPS DAILY _____
DIET: SALT INTAKE _____	CONTINUITY DISTURBANCES ____	HOW LONG _____	
FAT INTAKE _____	EARLY MORNING AWAKENING ____	INTERESTED IN STOPPING?_____	OTHER CAFFEINE _____
OTHER _____	DAYTIME DROWSINESS _____	EXCERSISE ROUTINE: _____	
	OTHER_____	_____	