**HISTORY AND PHYSICAL**

Name _____ Age____ Date of Birth _____ Date _____

To properly care for you, we need a **complete and thorough** summary of your medical history. Male____ Female____

What is your chief complaint?_____

_____

_____

Circle dominant side: Right or Left

Family Doctor/Internalist: _____

Drug and other allergies: _____

_____

Current Medications:

_____

_____

_____

_____

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_____

_____

**SOCIAL HISTORY:**

Married? Yes No

Occupation: _____

Persons with whom you live: _____

Number of children: _____ Number of Live Births: _____

Are you pregnant? Yes No Date of last menstrual period_____

Tobacco use? Yes No Packs per day_____ _____

Years of tobacco use_____

Alcohol use (circle) None Rarely Moderate Daily

**FAMILY HISTORY:**

Any history of osteoarthritis, rheumatoid arthritis, gout, back surgeries, disc disease, anesthetic problems, diabetes, bleeding disorders, mental illness, heart or stroke problems, etc.

Mother: _____

Father: _____

Maternal Grandparents: _____

Paternal Grandparents: _____

Siblings: _____

**HEALTH MAINTENANCE:**

List last physical exam and date Date

EKG

CXR

MAMMO

PATIENT SIGNATURE _____

**** Current & Past Problems &Surgeries On Next Page****

**SYSTEMS REVIEW** (circle)

CONSTITUTION/ GENERAL

| | | |
|---|---|---|
| General Health: Good Fair Poor | | |
| Recent weight gain or loss | No | Yes |
| Complaints of fever | No | Yes |
| Reactions to anesthesia | No | Yes |

HEMATOLOGIC

| | | |
|---|---|---|
| Bruise Easily | No | Yes |
| Tendency to bleed excessively | No | Yes |
| History of Blood Clotting | No | Yes |

CENTRAL NERVOUS AND PSYCHIATRIC

| | | |
|---|---|---|
| Difficulty sleeping | No | Yes |
| Troubled by depression | No | Yes |
| Troubled by anxiety | No | Yes |
| Psychiatric illness | No | Yes |
| Mental health illness | No | Yes |
| Severe headaches | No | Yes |
| Problems with dizziness | No | Yes |
| Seizures or convulsions | No | Yes |

RESPIRATORY AND CARDIOVASCULAR

| | | |
|---|---|---|
| Cough | No | Yes |
| Shortness of breath | No | Yes |
| Chest pain | No | Yes |
| Palpitation/fluttering heart | No | Yes |
| Elevated blood pressure | No | Yes |
| Pacemaker or Defibrillator | No | Yes |

GENITOURINARY/ GASTROINTESTINAL

| | | |
|---|---|---|
| Burning with urination | No | Yes |
| Frequent urination | No | Yes |
| Mentural cylcle problems | No | Yes |
| Prostate problems | No | Yes |
| Stomach pain or burning | No | Yes |
| Frequent loose stools | No | Yes |
| Frequent constipation | No | Yes |
| MUSCULOSKELETAL | No | Yes |
| Joint pain | No | Yes |
| Rheumatoid arthritis | No | Yes |
| Gout | No | Yes |
| Back problems | No | Yes |
| SKIN/ BREAST | No | Yes |
| Frequent rashes | No | Yes |
| Breast pain or tenderness | No | Yes |
| Nipple discharge | No | Yes |
| Breast lumps or masses | No | Yes |

ENDOCRINE

| | | |
|---|---|---|
| Excessive thirst | No | Yes |
| Excessive urination | No | Yes |

HEENT

| | | |
|---|---|---|
| Difficulty swallowing | No | Yes |
| Ringing or Drainage in ears | No | Yes |
| Frequent earaches | No | Yes |
| Wear glasses/ contacts | No | Yes |
| Uncorrectable hearing | No | Yes |
| Double or blurry vision | No | Yes |

CURRENT & PAST PROBLEMS AND SURGERIES

including serious and chronic illnesses

Date Current Medical Problems Doctor

_____

_____

_____

_____

_____

_____

_____

_____

| Date | Past Medical Problems & Surgeries | Doctor/Surgeon |
| --- | --- | --- |
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PATIENT SIGNATURE