



## HISTORY and PHYSICAL EXAMINATION

Please fill out all the questions to the best of your knowledge. This information will become part of your medical record and will allow us to provide thorough medical care. It is very important to us and will be kept confidential.

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Business Phone \_\_\_\_\_  
Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender \_\_\_\_ SS # \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_

### HISTORY

What is the **complaint, pain, or injury** that caused you to schedule an appointment to see the doctor?  
(Provide dates and details of when and how the pain began or injury occurred)

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### PAST MEDICAL HISTORY

CHILDHOOD DISEASES – check all that apply

- Measles     Mumps     Chickenpox     Rheumatic Fever     Pneumonia     Asthma  
 Other \_\_\_\_\_

ADULT ILLNESSES/DISEASES – check all that apply and indicate the year

- Stroke \_\_\_\_\_     Heart Attack \_\_\_\_\_     Ulcers \_\_\_\_\_  
 Pneumonia \_\_\_\_\_     Heart Failure \_\_\_\_\_     Diabetes \_\_\_\_\_  
 Emphysema \_\_\_\_\_     Heart Irregularity \_\_\_\_\_     Bladder Infection \_\_\_\_\_  
 Asthma \_\_\_\_\_     Kidney Stones \_\_\_\_\_     Kidney Infection \_\_\_\_\_  
 Tuberculosis \_\_\_\_\_     High Blood Pressure \_\_\_\_\_

PREVIOUS HOSPITALIZATION (other than surgeries) – list reason, date, hospital

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PAST SURGERIES – list type and year

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**CURRENT MEDICATION**

Name	Strength (mg)	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**DRUG ALLERGIES** – List the drug and your reaction  
i.e., hives(rash), swelling, asthma, fever, itching, nausea does not imply an allergy but  
please list. If you have no allergies please write NONE.

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY**

**Has any member of your family died or become seriously ill following anesthesia?**  Yes  No

If yes please provide details \_\_\_\_\_

**IMPORTANT: PLEASE COMPLETE THE SECTION BELOW AS THOROUGHLY AS POSSIBLE**

	Age	Living/deceased	Serious illnesses/cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Is there a family history (parents, grandparents, siblings, children, immediate aunts, uncles) of:

- Diabetes  Tuberculosis  Hemophilia (bleeding tendencies)
- Cancer  Heart Disease (heart attack, stroke, hardening of the arteries, high blood pressure)
- Kidney Disease  Dwarfism  Rickets
- Bone or joint abnormalities (crippling arthritis)  Epilepsy (seizures)
- Nervous or mental disorders

**PERSONAL and SOCIAL HISTORY**

Do you drink alcoholic beverages?  Yes  No

If yes, how much per week? \_\_\_\_\_

Do you smoke?  Yes  No

If yes, how many packs per week? \_\_\_\_\_ How long? \_\_\_\_\_

Age and health of spouse \_\_\_\_\_

Any person, family, or job problems that might pertain to your situation/recovery?

\_\_\_\_\_  
\_\_\_\_\_

Military  Yes  No Education level \_\_\_\_\_ Religion \_\_\_\_\_

Previous occupations \_\_\_\_\_

Any exposure to dangerous/toxic materials or poisons? \_\_\_\_\_

**REVIEW OF SYSTEMS** – Check all that apply

GENERAL HEALTH  Good  Fair  Bad

Recent:

- |                                      |  |   |                                 |
|--------------------------------------|--|---|---------------------------------|
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain     | <input type="checkbox"/> Sweats           | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Fever       | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Trouble Sleeping |                                 |

**SKIN**

- |                                      |                               |                                |                                    |
|--------------------------------------|-------------------------------|--------------------------------|------------------------------------|
| <input type="checkbox"/> Rashes      | <input type="checkbox"/> Acne | <input type="checkbox"/> Scars | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Other _____ |                               |                                |                                    |

**EYE**

- |   |                                      |                                    |                                   |
|---|--------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Glasses        | <input type="checkbox"/> Contacts    | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Other _____ |                                    |                                   |

**EAR, NOSE and THROAT**

- |   |  |  |                                      |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Dentures or partial plates | <input type="checkbox"/> Braces            | <input type="checkbox"/> Caps                                  | <input type="checkbox"/> Loose teeth |
| <input type="checkbox"/> Taste problems             | <input type="checkbox"/> Smelling problems | <input type="checkbox"/> Recent sore throat or sinus infection |                                      |
| <input type="checkbox"/> Ringing in ears            | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Neck Lumps/masses                     |                                      |

**GLANDULAR PROBLEMS**

- |                                  |                                 |                                  |                                    |
|----------------------------------|---------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Goiter | <input type="checkbox"/> Ovaries | <input type="checkbox"/> Testicles |
|----------------------------------|---------------------------------|----------------------------------|------------------------------------|

**ENDOCRINE PROBLEMS**

- |   |                                    |   |
|---|------------------------------------|---|
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Urination | <input type="checkbox"/> Growth of hair |
|---|------------------------------------|---|

**ALLERGY**

- |                                      |                                 |                                |                                |
|--------------------------------------|---------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> Hay fever   | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hives | <input type="checkbox"/> Metal |
| <input type="checkbox"/> Other _____ |                                 |                                |                                |

**HEART/VASCULAR**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Chest pain               | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Heart attack              |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Dyspnea             | <input type="checkbox"/> Rheumatic fever           |
| <input type="checkbox"/> Heart murmur             | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hardening of the arteries |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Dropsy                    |
| <input type="checkbox"/> Ankle swelling           | <input type="checkbox"/> Racing heart beat   | <input type="checkbox"/> Palpitation               |
| <input type="checkbox"/> Irregular beat           |  |  |

**LUNG**

Current or recent:

- |                               |                                |   |
|-------------------------------|--------------------------------|---|
| <input type="checkbox"/> Cold | <input type="checkbox"/> Cough | <input type="checkbox"/> Sore throat or infection |
|-------------------------------|--------------------------------|---|

History of:

- |                                     |                                    |  |
|-------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Pleurisy   | <input type="checkbox"/> Cough     | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Sputum    | <input type="checkbox"/> Wheezing          |
| <input type="checkbox"/> Smoking    | <input type="checkbox"/> COPD      | <input type="checkbox"/> Emphysema         |

**GASTRO-INTESTINAL**

- Hepatitis
- Tonsillitis
- Gallbladder
- Hemorrhoids
- Vomiting
- Recent bleeding
- Laxatives
- Use of antacids
- Jaundice
- Esophagitis
- Change of bowel habits
- Piles
- Diarrhea
- Tarry (black) stools
- Food allergies or intolerance
- Irregularity
- Mouth problems
- Hernia
- Typhoid fever
- Nausea
- Constipation
- Appendicitis
- Heartburn
- Pain before or after meals

**KIDNEY/BLADDER**

- Kidney/bladder infections
- Frequent voiding
- Syphilis
- Nephritis
- Incontinence
- Urinating at night, number of times per night \_\_\_\_\_
- Bleeding
- Bladder trouble (list below)
- Gonorrhoea
- Discharge
- Obstruction
- Pain or burning on urination
- Stones
- Hydrocele
- Strictures

**GYNECOLOGICAL**

- Could you be pregnant now?  Yes  No      Date of last period \_\_\_\_\_
- Number of pregnancies \_\_\_\_\_      Live births \_\_\_\_\_
- Menstrual history:    Age at onset \_\_\_\_\_      Frequency \_\_\_\_\_      Duration \_\_\_\_\_
- Menopause (change of life)  Yes  No      Age \_\_\_\_\_
- Any bleeding or spotting since menopause? \_\_\_\_\_

**BONE MARROW**

- Anemia
- Bleeding or bruising tendencies
- Radiation
- Benzene or other exposure? \_\_\_\_\_

**NEUROMUSCULAR (provide details below)**

- Headaches
- Paralysis
- Numbness
- Sciatica
- Ruptured muscles
- Rheumatism
- Partial or complete amputations
- Visual disturbances
- Stroke
- Convulsions
- Neck pain or injury
- Torn ligaments
- Gout
- Dizziness
- Forgetfulness
- Epilepsy
- Arthritis
- Severe/recurrent sprains
- Phlebitis
- Pain or cramps when walking
- Blackouts
- Head Injury
- Back pain
- Trick knees

**PSYCHIATRIC PROBLEMS**

- Nervous breakdown
- Severe anxiety
- Depression
- Suicidal
- Other \_\_\_\_\_

**COMMENTS/EXPLANATIONS:**

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