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History and Physical Information

Name____**Date of Birth**________________**Date**_________________
Allergies/Drug Allergies____
____
Medications:____
____

Surgery:	Details	Date/Hospital
_Appendectomy	______________________________	_________________________
_Breast	______________________________	_________________________
_Gallbladder	______________________________	_________________________
_Hernia repair	______________________________	_________________________
_Hysterectomy	______________________________	_________________________
_Other abdominal	______________________________	_________________________
_Tonsillectomy	______________________________	_________________________
_Other Not Listed	______________________________	_________________________
_Blood transfusion	______________________________	_________________________

Year of Last: Tetanus________Flu________Pneumonia________Other________

Medical History

_Abdominal pain- chronic
_Allergies/Asthma
_Anemia/Bruise easily
_Anxiety
_Arthritis/Rheumatism
_Back Pain- Recurrent
_Cancer
_Chest Pain
_Convulsions/Seizures
_Depression
_Diabetes
_Diarrhea/Constipation
_Dizziness/Fainting
_Fatigue-Chronic
_Gallbladder trouble
_Gout
_Headaches- Frequent
_Heart Murmur
_Hemorrhoids/bloody BM
_Hernia
_High Blood Pressure
_High Cholesterol
_HIV
_Indigestion/Heartburn
_Jaundice/hepatitis
_Kidney failure
_Kidney Stones
_Nose Bleeds
_Numbness/tingling
_Osteoporosis
_Pneumonia
_Prostate disease
_Sexually Transmitted disease
_Sinus Trouble
_Skin Rash/Hives
_Sleep disorders
_Stroke
_Thyroid disease
_Tremors/Hands shaking
_Tuberculosis
_Ulcers- Peptic

Date of last Colonoscopy _________Date of last Stress Test ________Date of last Bone Density ________
Date of 1st day of last period___________Number of: ___Pregnancies___Abortions___Miscarriages___Live Births
Birth control method_______________________Date of last PAP___________ normal__abnormal__
_Flushing/Menopause Date of last Mammogram__________

Family History

		Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism		_	_	_	_	_	_
Cancer		_	_	_	_	_	_
Diabetes	_	_	_	_	_	_	
Heart Disease		_	_	_	_	_	_
High Blood pressure		_	_	_	_	_	_
High Cholesterol		_	_	_	_	_	_
Kidney Disease		_	_	_	_	_	_
Mental Illness		_	_	_	_	_	_
Migraine		_	_	_	_	_	_
Osteoporosis		_	_	_	_	_	_
Stroke		_	_	_	_	_	_
Thyroid Disease		_	_	_	_	_	_

Social History

Tobacco _No _Yes _Quit/When_____Packs/day____ # years____ Tattoos _No _Yes
Alcohol _No _Yes _Quit/When_____Drink/wk____ # years____ Caffeine: Type________ Amount a day________
Recreational Drug Use _No _Yes _Quit/When_____ Drugs used_________ Were needles used _No _Yes
Diet: _Vegetarian _Lactose-free _Caffeine-free _Diabetic _Regular _Other________________
Exercise _No _Yes How often?______Marital Status: _Married _Single _Divorced _Widow/Widower