

History and Physical

LOGO

Name: _____
Date: _____ Age: _____

Past Medical History

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Heart Attack/disease | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Pnemonia |
| <input type="checkbox"/> DVT | <input type="checkbox"/> Kidney stone/problem | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Valley Fever |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma/emphysema | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Degenerative Arthritis | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> thyroid problem | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> peptic ulcer |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatits/ liver problem | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> stroke |
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Other | |

Past Surgical History

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> tonsillectomy | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Knee(L or R) | <input type="checkbox"/> Shoulder(L or R) | <input type="checkbox"/> Hip(L or R) |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Hernia | <input type="checkbox"/> Back |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Breast |
| <input type="checkbox"/> Other | | |

Medications

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies (reactions)

- | | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Immunizations

- | | | |
|--|---|---|
| <input type="checkbox"/> Tetnus(19__) | <input type="checkbox"/> Influenza (within last year) | <input type="checkbox"/> Hepatitis B (19__) |
| <input type="checkbox"/> Pneumovax(19__) | <input type="checkbox"/> Chicken Pox Vaccine | <input type="checkbox"/> Other _____ |

Social History

Occupation _____ Marital Status: Single() Married() Widowed() Divorced ()
 Tobacco Now() Never() In the Past() Amount per day _____ Year quit _____ Age started _____
 Alcohol Now() Rare() Occasional() Moderate () Heavy() Amount/ type per day _____

Family History

	Major Medical Problem	Age of Death	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother	_____	_____	_____
Sister	_____	_____	_____
Children	_____	_____	_____

Family History of: Cancer () Diabetes () High Blood Pressure() Heart Problems()