

History and Physical Form

Date	Patient Name	Gender	Age	Date of Birth	Referring Physician
		<input type="checkbox"/> M <input type="checkbox"/> F			

History of Present Illness:

What is the reason for your appointment?

When did this problem start?

How severe is the problem?

What makes it worse?

What helps?

Is it worse at certain times of the day or night?

Physician Notes

Please check only those items which apply to your personal medical history.

- | | | |
|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung problems / Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Peptic Ulcers | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Accidents /broken bones |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Chest pain/Tightness | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Prostate | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> HIV | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Abdominal Bleeding | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Other |

Previous Hospitalizations/Surgeries: (not including pregnancy)

Year	Illness/Surgery	Year	Surgery

Current Medications: (including vitamins and over the counter medications)

Medication	Dosage	Medication	Dosage
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Please List All Allergies:

1.	3.
2.	4.

Family History: Check only the conditions if a blood relative has suffered.

- | | | | | |
|--|--------------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Brain Tumors |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lipid Disorder | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Other | | | | |

Patient Signature: _____ **Date:** _____

